DOCUMENT RESUME

ED 214 642 PS 012 729

TITLE Medicaid Cutbacks on Infant Care. Hearing Before the Subcommittee on Oversight and Investigations and the Subcommittee on Health and Environment of the Committee on Energy and Commerce, House of Representatives, Ninety-Seventh Congress, First Session (July 27, 1981).
INSTITUTION Congress of the U.S., Washington, D.C. House.
PUB DATE 82
NOTE 103p.

EDRS PRICE MF01/PC05 Plus Postage.
DESCRIPTORS *Economically Disadvantaged; *Federal Aid; Health Services; Hearings; *Infants; *Medical Services; *Mothers; Pregnancy; *Retrenchment; Social Problems
IDENTIFIERS Congress 97th; *Medicaid; Reagan Administration

ABSTRACT

The purpose of these Hearings of Subcommittees of the Committee on Energy and Commerce, U.S. House of Representatives, is to investigate the effects of medicaid cutbacks on infant health. After introductory statements by the chairmen of the House Subcommittee on Oversight and Investigations and the House Subcommittee on Health and the Environment, the testimony of medical experts from Florida and Alabama is reported verbatim. In addition, testimony from a Texas legal services agency is reported. The difficulties of the poor in obtaining neonatal care for pregnant women is repeatedly described by the witnesses, and an overview of the impact of medicaid and other Federal health programs on the health of the poor is provided. Also included is a policy paper from the national health law program. In the paper, statistics on maternal care for the poor, denial of prenatal and delivery care, the effects of medicaid cuts on public hospitals, plus proposed reductions in federal health programs for the poor are discussed. Concluding testimony records the positions taken by witnesses representing the Reagan administration's perspective on the issues raised. (Author/RH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

PS

MEDICAID CUTBACKS ON INFANT CARE

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

ED214642

PS012729

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

AND THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

FIRST SESSION

JULY 27, 1981

Serial No. 97-69

Printed for the use of the
Committee on Energy and Commerce

U.S. GOVERNMENT PRINTING OFFICE
89-262 O WASHINGTON : 1982

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

JAMES H. SCHEUER, New York
RICHARD L. OTTINGER, New York
HENRY A. WAXMAN, California
TIMOTHY E. WIRTH, Colorado
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFETT, Connecticut
JIM SANTINI, Nevada
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
ALBERT GORE, Jr., Tennessee
BARBARA A. MIKULSKI, Maryland
RONALD M. MOTTL, Ohio
PHIL GRAMM, Texas
AL SWIFT, Washington
MICKEY LELAND, Texas
RICHARD C. SHELBY, Alabama
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
W. J. "BILLY" TAUZIN, Louisiana
RON WYDEN, Oregon
RALPH M. HALL, Texas

JAMES T. BROYHILL, North Carolina
CLARENCE J. BROWN, Ohio
JAMES M. COLLINS, Texas
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
MARC L. MARKS, Pennsylvania
TOM CORCORAN, Illinois
GARY A. LEE, New York
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
THOMAS J. TAUKE, Iowa
DON RITTER, Pennsylvania
HAROLD ROGERS, Kentucky
CLEVE BENEDICT, West Virginia
DAN COATS, Indiana
THOMAS J. BLILEY, Jr., Virginia

Frank M. Potter, Jr., *Chief Counsel and Staff Director*
Sharon E. Davis, *Chief Clerk/Administrative Assistant*
Donald A. Watt, *Printing Editor*
Randall E. Davis, *Minority Counsel*

Subcommittee on Oversight and Investigations

JOHN D. DINGELL, Michigan, *Chairman*

JIM SANTINI, Nevada
DOUG WALGREN, Pennsylvania
ALBERT GORE, Jr., Tennessee
RONALD M. MOTTL, Ohio
THOMAS A. LUKEN, Ohio
RICHARD C. SHELBY, Alabama
MIKE SYNAR, Oklahoma
W. J. "BILLY" TAUZIN, Louisiana
RON WYDEN, Oregon

MARC L. MARKS, Pennsylvania
NORMAN F. LENT, New York
BOB WHITTAKER, Kansas
DON RITTER, Pennsylvania
HAROLD ROGERS, Kentucky
DAN COATS, Indiana
JAMES T. BROYHILL, North Carolina

Michael F. Barrett, *Chief Counsel/Staff Director*
Susan Leal, *Counsel*
Elliot A. Segal, *Special Assistant*
Michael J. Stewart, *Associate Minority Counsel*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HENRY A. WAXMAN, California, *Chairman*

JAMES H. SCHEUER, New York
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
BARBARA A. MIKULSKI, Maryland
RON WYDEN, Oregon
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFETT, Connecticut
RICHARD C. SHELBY, Alabama
PHIL GRAMM, Texas
MICKEY LELAND, Texas
JOHN D. DINGELL, Michigan
(Ex Officio)

EDWARD R. MADIGAN, Illinois
CLARENCE J. BROWN, Ohio
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
DON RITTER, Pennsylvania
CLEVE BENEDICT, West Virginia
THOMAS J. BLILEY, JR., Virginia
JAMES T. BROYHILL, North Carolina
(Ex Officio)

KAREN NELSON, *Staff Director*
ANDREAS G. SCHNEIDER, *Assistant Counsel*
W. SCOTT WILBER, *Associate Minority Counsel*

CONTENTS

Testimony of:

Page
Curran, Dr. John S., acting medical director, Newborn Intensive Care Unit, Tampa, Fla., General Hospital 6
Davis, Karen, professor, Johns Hopkins School of Public Health 27, 40
Eitzman, Dr. Donald, distinguished service professor of pediatrics, University of Florida at Gainesville 6, 9
Goldenberg, Dr. Robert, obstetrician, University of Alabama Medical School 27
Hiscock, William, Acting Director, Office of Child Health, Health Care Financing Administration, Public Health Service, Department of Health and Human Services 75
Kovar, Mary Grace, Special Assistant for Data Policy and Analysis, Interview and Examination Statistics Program, National Center for Health Statistics, Public Health Service, Department of Health and Human Services 75
Mendez, Vivian B., North Central Legal Services, Dallas, Tex. 27, 37
Muse, Donald N., Branch Chief, Medicaid Program Data Branch, Health Care Financing Administration, Public Health Service, Department of Health and Human Services 75
Willging, Paul R., Deputy Administrator, Health Care Financing Administration, Public Health Service, Department of Health and Human Services 75

Material submitted for the record by:

Mendez, Vivian B., attachment to prepared statement: Article from the Avalanche-Journal entitled "Saving Lives of Poor Poses Economic Riddle" 39
National Health Law Program, Geraldine Dallek, health policy analyst, statement 56

Oversight and Investigations Subcommittee:

Letter from Dr. Joel C. Kleinman, Director, Division of Analysis, National Center for Health Statistics, Department of Health and Human Services, to subcommittee staff transmitting national data on infant and child health 77
Letter from Dr. George A. Little, chairman, Committee on Fetus and Newborn, American Academy of Pediatrics, to Chairman Dingell re the effects of medicaid cutbacks on infants and children 98

MEDICAID CUTBACKS ON INFANT CARE

MONDAY, JULY 27, 1981

House of Representatives, Subcommittee on Oversight and Investigations, and Subcommittee on Health and the Environment of the Committee on Energy and Commerce,
Washington, D.C.

The subcommittees met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Albert Gore presiding (Hon. John D. Dingell, chairman, Subcommittee on Oversight and Investigations; Hon. Henry A. Waxman, chairman, Subcommittee on Health and the Environment).

Mr. Gore. The subcommittees will come to order.

President Reagan in announcing his economic recovery program, promised the Congress and the American people that the truly needy members of our society would be protected by a safety net of social programs. Today the Subcommittee on Oversight and Investigations and the Subcommittee on Health and Environment meet jointly to examine just how tightly this net is being woven.

We are focusing our inquiry on the effects of medicaid cutbacks on infant health. I requested this hearing several weeks ago when attention was brought to a tragic series of events in Florida.

A premature infant, child of an indigent couple, was denied admission to a neonatal intensive care unit because of funding reductions at the hospital. A short time later the infant died in another public hospital, one that lacked the extraordinary lifesaving equipment found in neonatal intensive care facilities. We cannot know whether the child would have lived had admission been granted, but we do know unequivocally there would have been a much greater chance.

The high cost of providing neonatal intensive care, coupled with the disproportionate need for such care by infants born into low-income families, creates stress on the various sources of public support for these programs. Medicaid in particular is a major source of support for neonatal intensive care units in public hospitals.

Today's hearing will demonstrate that the problems in Florida are really national problems. As State medicaid funding crises are exacerbated by cutbacks in Federal support, the already severe strains on publicly supported neonatal intensive care will be greatly increased.

Public officials in Florida have been confronted with the wrenching decision to turn infants away and this is occurring in other States as well. We will hear testimony that similar situations are occurring in Texas and Alabama. At Syracuse University, which operates an extensive regional neonatal intensive care system, there have been public threats to refuse admission to medicaid mothers unless the State provided additional financial support.

In view of the difficulties that currently plague this system it is critically important to consider the impact that a federally imposed cap on medicaid spending would have on these and other programs. The public is entitled to know the effects of the changes that are being contemplated.

I would ask unanimous consent that the prepared opening statement of Chairman John Dingell be included into the record at this point, and Chairman Henry Waxman of the Health Subcommittee.

STATEMENT OF HON. JOHN D. DINGELL

Mr. DINGELL. The Chair would like to welcome you to the hearing on the potential impact of Federal medicaid cutbacks on care for children. Infant mortality—the deaths of newborns in this country—has been reduced significantly over the past 15 years; many experts credit this great improvement to the added resources provided by the medicaid program. Today, we will examine how this reduction in children's deaths may be jeopardized by the proposed medicaid cap suggested by the Reagan administration.

The Oversight and Investigations Subcommittee has been active on two fronts in the medicaid area: Attempting to eliminate waste, fraud, and abuse in the program and insuring that appropriate care is provided to children and elderly as needed.

In the past the subcommittee has found that the Department of Health and Human Services was shortchanging children with its maladministration of the early periodic screening, diagnosis, and treatment programs [EPSDT]. We even found medicaid programs were not providing such basic requirements as polio vaccinations for children.

Recently, we have learned that States have begun to institute serious cutbacks in their State health programs including the medicaid benefits. The Chair believes it is important to examine what impact these cutbacks would have on the health of children. We intend to look at the harm these cutbacks cause to the Federal, State, and local governments, and to maternal and child health. This year an estimated 46,000 infants will die.

A disproportionate number of these children will be poor, will be black, and will be medicaid recipients. By cutting back on Federal medicaid funds for neonatal and other health care programs we have to ask:

Will we be increasing the rate of infant mortality in this country?

Will we be putting a halt to the improvements that have been made by medical experts and medical technology over the past 15 years?

We will examine specific allegations that a premature baby died after being denied available hospital care because the doctors in the hospital were following orders to cut costs. We will hear that this is not an isolated case. From information that we have gathered it appears that there may be several hundred such cases annually across the country. According to a report prepared for this subcommittee by the National Health Law Project it appears that this problem is growing at alarming proportions.

It is important that we question the Department of Health and Human Services to learn what went into their decision to propose a medicaid cap and how much consideration they gave to the potential problems that would result from such a significant program change. This includes the potential for increasing infants deaths, disabling illnesses, and even increasing rather than decreasing the Government's expenditures for health care in this country.

STATEMENT OF HON. HENRY A. WAXMAN

Mr. **Waxman**. Those of you in attendance this morning understand that the Congress has reached a critical moment in its consideration of health legislation. Our hearing this morning will focus on just one aspect of the many health issues we have been trying to resolve over these many weary weeks—the issue of health care for infants and children.

This is a joint hearing of the Subcommittee on Health and the Environment, and the Subcommittee on Oversight and Investigations, chaired by the chairman of the full Energy and Commerce Committee, our distinguished colleague, John Dingell. This hearing follows up on one held earlier this year, which received testimony from members of the Select Panel for the Promotion of Child Health.

The purpose of today's hearing is to remind us all of a stark reality. When we sit in conference, when we argue over sections and paragraphs, when we lobby for particular programs, we sometimes forget what we are really dealing with. This morning, we won't be able to forget. As our witnesses will testify, the results of our actions in Congress, the consequences of the budget cuts and the cap on medicaid recommended by the administration, affect the children of this country. A decision to impose a limit on medicaid funds can result in program cuts which will increase their suffering, their pain, and may indeed, lead to untimely deaths.

We hear much these days about the right to life for the unborn. Today we will hear about the denial of that right to one already born, to an innocent life cut short by our society's callous refusal to guarantee decent medical care to all Americans.

America's rate of infant mortality is a national disgrace. For years we have trailed other industrialized nations in efforts to insure that newborn babies survive to enjoy the joys of childhood.

I and other Members of Congress have tried to reverse this trend, to help America close the gap and at least reach the level of mortality of other Western nations, by supporting the expansion and sharpening the emphasis of our health programs. During the past decade, Federal health programs have begun to significantly improve the well-being of infants and children. The infant mortality rate has dropped over 30 percent from 1970 to 1978.

Much remains to be done, especially for poor and black families whose babies continue to suffer from very high death rates. Now it seems that we have to concern ourselves merely with trying to prevent this administration from eroding our standing, from pushing us further behind other nations.

The cap on medicaid will be a very real barrier in these efforts to provide a good beginning for all our Nation's babies.

We know that countless women are now denied prenatal care by hospitals and physicians because of the low rate of medicaid reimbursement. A cap will deny thousands more.

We know hundreds of thousands of women and children have no access to medical care because, though desperately poor, they have incomes above pitifully low medicaid eligibility standards. A cap will add thousands more.

We know hundreds of thousands of mothers and infants now get care in community and migrant health centers. A cap on medicaid, a cut in programs, will close even these doors.

I do hope that testimony we hear today will impress itself on our Members as they deal with the so-called reconciliation bill, legislation which threatens not to reconcile our society but to tear it apart.

Thank you all for coming, and I look forward to receiving the testimony.

Mr. **Gore**. I would like to call now on the ranking minority member of the Oversight and Investigations Subcommittee, Mr. Marks.

Mr. **Marks**. Thank you very much, Mr. Gore.

I would like to welcome our witnesses today. Some of you have traveled quite far to be here. Speaking certainly for my minority colleagues, I want you all to know that we appreciate your coming and your testimony.

As father of three children I am very much aware of the importance of good basic health care early in life. In fact, we can all be proud of our health care delivery system in this country and note that the life expectancy in America has shown dramatic improvement based in large part on early care.

Much will be said today, I am sure, about the probable adverse effects on children of reduced funding for medicaid, and I intend to pay close attention to the testimony, as we all should.

No one here wants a needy child to suffer without health care. However, as we listen we should keep I think a couple of things in mind:

First, it is my understanding that the administration's proposal still requires that States must continue to cover currently mandated services provided to the categorically needy. The witness from the Department should be able to detail how this will work.

Second, the conferees I am advised have created a block grant specifically for maternal and child health.

Third, I hope we will keep in mind also what we are discussing here today is a reduction in the allowable increase in funding, something very different than a cut below what we now spend annually. Morever, it is my understanding that the conferees are not wedded to a cap but would very likely allow a much larger increase than earlier discussed.

Mr. Chairman, I believe this is an important issue and I am anxious, as I know you are, to hear the HHS, the Department, quiet the fears of those needy families who depend on medicaid for neonatal care.

I thank you.

Mr. Gore. I thank my colleague.

I would like to recognize one of the members of the Health and Environment Subcommittee, Mr. Leland.

Mr. Leland. Thank you.

Mr. Chairman, I am indeed honored to share the chair with you this morning at the request of my chairman, Mr. Henry Waxman, of this joint hearing today concerning the potential impact of medical cutbacks on care for children. Providing health care services for children has always been a priority of mine and I am even more concerned about the future of health care for children today because of the fiscal constraints on both Federal and State budgets.

Medicaid has been the one Federal program that has been responsible for reducing the number of infant mortality cases. Yet blacks, Hispanics, and other minority groups have disproportionately much higher rates of infant mortality than nonminorities.

In my own district the 18th Congressional District of Houston, the infant mortality rate in some of the census tracts there is as high as the infant mortality rate in Hong Kong and sometimes even exceeds that rate.

We are here today to determine the consequences of these proposed cutbacks for the Nation's program for poor people and what these cuts mean for blacks, Hispanics, women, and of course our Nation's most precious resources, our children.

Under the Reagan proposals medicaid payments would be capped and cut by $1 billion in fiscal year 1982, and by $5 billion in 1985.

In return for immediate cutbacks, the administration offers States added flexibility to targeted services to the truly needy. But let's not forget half of America's poor are ineligible for medicaid and millions more have little to no private insurance. This year 25 States have proposed further medicaid reductions and strapped municipalities are cutting public hospitals and clinics even as more uninsured patients seek care. It is because of the severe cutbacks that we in Congress must now know what the impact will truly be.

I now would like to yield to you, Mr. Chairman, for the rest of the hearing.

Mr. Gore. Thank you very much.

Mr. Dannemeyer?

Mr. Dannemeyer. Thank you, Mr. Chairman.

My home State of California, the annual State budget is around $25 billion currently. Estimates for medicaid spending, what we call the Medi-Cal in California, run around $5 billion in the next fiscal year.

As we know, the current formula is a 50-50 match so that means that the State is paying about $2.5 billion in the next fiscal year in California for Medi-Cal expenditures—which is about 10 percent of our State budget—for a relatively small but necessary population base in our State.

It is interesting to me to note that of the two proposals that were considered by our Commerce Committee, which we never really came to resolution on, the Broyhill substitute, with a cap of 7.5 percent as it was considered on the last day, actually contained more money for medicaid expenditures nationwide than did the Waxman substitute with its percentage reduction formula.

What comes out of the conference committee that is currently working today, to my knowledge, has yet to be resolved. But I am sure that the compromise, which will be developed will recognize the conflict between the desire of taxpayers for a reduction in the growth of Federal spending, and the necessity of providing the medical care for the poor people of this country.

Thank you.

Mr. **Gore**. Thank you very much.

I would like to call our first witness, Dr. John Curran from the Tampa General Hospital in Tampa, Fla.

I believe you are accompanied, Dr. Curran, by Dr. Donald Eitzman, distinguished service professor of pediatrics from the University of Florida in Gainesville.

Will you be offering testimony, Dr. Eitzman?

Dr. **Eitzman**. Yes.

Mr. **Gore**. Would both of you stand and raise your right hand? We have a tradition of swearing witnesses.

[Dr. Curran and Dr. Eitzman were duly sworn.]

Mr. **Gore**. If you would repeat to the reporter your full name for the record.

Dr. **Eitzman**. Donald Bern Eitzman.

Dr. **Curran**. John Curran, C-u-r-r-a-n.

Mr. **Gore**. Dr. Curran, welcome. We appreciate you coming and helping us explore this issue.

Without objection from any of my colleagues, we will put the entire text of your statement in the record, or invite you to go ahead and present it orally. If you want to summarize it, that is fine; if you want to read it, that is fine too. You use your own discretion and please proceed.

TESTIMONY OF DR. JOHN S. CURRAN, ACTING MEDICAL DIRECTOR, NEWBORN INTENSIVE CARE UNIT, TAMPA (FLA.) GENERAL HOSPITAL; AND DR. DONALD EITZMAN, DISTINGUISHED SERVICE PROFESSOR OF PEDIATRICS, UNIVERSITY OF FLORIDA AT GAINESVILLE

Dr. **Curran**. Thank you, Mr. Chairman.

Mr. Chairman and members of the Subcommittee on Oversight and Investigations, staff and guests, I am here to discuss some details of newborn health care in the State of Florida.

Carl Downing, Jr., was born in his mother's bed in Dade City in rural Pasco County, Fla., at 5 a.m., July 2, 1981. Little did he know that the next few hours of his short life would receive national attention, focusing on today's problems of access to high technology, expensive but cost-effective neonatal intensive care.

The infant's first breaths were labored, he was assisted by emergency medical technicians and taken to the nearest hospital, a hospital incorporated for profit, where minimal medical support was available to the poor. The nearest county public facility for obstetric care is 42 miles away in West Pasco County; his mother had not received prenatal care as the county government had terminated prenatal and obstetric care in Dade City some months before as an economy measure.

Supportive care was given, but no pediatrician was available in that community; frenzied calls began to the statewide CARE—Communication and referral—system to find a care center for the frail 2-pound 6-ounce infant with breathing difficulties of prematurity. The nearest center was in Tampa where a bed was available, nursing and medical personnel highly trained to care for the critically ill newborn were ready and willing, and a trained newborn transport team with a mobile intensive care unit was poised to take care to the patient to save a life.

At 5:30 a.m. that morning, the infant's chances were 7 in 10 that he could benefit from that care, live, and enjoy a productive life free of mental retardation.

Such was not to be, however. The public hospital in Tampa where the State-supported regional perinatal intensive care center is located had announced on June 11 a policy of the Hillsborough County Hospital Authority that no infants born outside the facility could be admitted to newborn special care until such time as 10 newborn special care beds had been eliminated. Why? In a purely financial decision and without consultation with its medical staff, the governing body implemented this decision to cut costs of the medically indigent although the total facility had shown a profit in the last fiscal year.

Such policies are far beyond the comprehension of physicians trained to save life; physicians may not understand the internal finances of hospitals but the moral and ethical dilemmas posed by such problems are placed upon society and the physicians ordered not to accept critically ill infants when a functional care area is available.

Infant Downing died at 10 a.m. without benefit of the assistance which could have been available, no other center could assist in part because of the withdrawal of access to 7 percent of the State's neonatal beds in Tampa.

Similarly, the plight of Stephanie McElrath, who was flown by USAF C-130 from Miami to Augusta, Ga., when care was not available in Florida, captured the Nation's attention and raised serious questions of accessibility and funding of newborn intensive care not only in Florida but in the Nation at a time when budget cuts in health programs are being considered.

Why should Florida be the focus of national attention for the care of its newborns? Florida should not be criticized but, rather, praised for the intense support of its Governors and legislatures for the advocacy of children's care from general revenue dollars beginning in 1974. Five State-supported centers and $1.5 million were appropriated that year to develop a model program of patient care, communication, transport, and evaluation of outcome; in 1977 the program was expanded to include more newborn centers and obstetrics care for mothers with high-risk perinatal conditions who met the financial qualifications for sponsorship.

In fiscal year 1979 approximately 3,400 infants were served by this system, 1,300 high-risk mothers, and approximately 2,500 developmental evaluations were performed; 76 percent of requests for placement in centers were accomplished when the nearest center was not available due to high utilization.

The total hospital and professional charges were $21.8 million—the centers were reimbursed $7.2 million. Therein has been the issue highlighted by the neonatal controversy in Florida—reimbursement from general revenue dollars, third-party health insurance, and title 19 funds have not been equal or directly related to cost of this expensive, highly technological, personnel-intensive care. Hospital administrative reactions at some centers have led to reduction of services, elimination of access to outborn infants in two centers in Florida, termination of involvement in the program by one center and a distinct lack of enthusiasm in getting new centers established.

Through major effort the 1981 Florida Legislature and Governor Robert Graham have doubled total program funding to $17 million; on the other hand, hospital administrators claim costs equal to $33.2 million for program participants; the result has been that infants are being held hostage to finances for health care.

Florida's births have increased from 107,000 in 1973 when its neonatal system was designed to 131,800 in 1980. Population growth of the State has been rapid; recent immigrant populations from Cuba and Haiti have contributed substantially to the need for neonatal health care service.

In addition, other factors which have complicated the financing of newborn health care services in Florida include:

First, Florida's medicaid program has been a bare minimum program in provision of services to children.

Second, restrictive medicaid access policies which do not cover the newborn of a medicaid participant from birth automatically but which require time-consuming retroactive procedures for certification that average 90 days.

Third, medicaid policies which provide care only to children of broken families, Aid for Dependent Children.

Fouth, limitation of inpatient services to 45 days which may be inadequate for many premature infants.

Fifth, the growth of private hospitals for profit which do not participate in medicaid and which inevitably cause public sector hospitals to face increasing losses by removing the patient with ability to pay.

The problems which I have reviewed and outlined are not unique to Florida but rather are more readily apparent because of an information system which shows statewide at any given moment the availability of care and attempts to maximize the delivery of that care. Provision of neonatal special care is primarily to those socioeconomic groups which have a high rate of prematurity: The pregnant teenager, the poor, the black, the Hispanic, and recent immigrant groups. We will present the cost-effectiveness of such care in saving precious human resources.

Potential reductions in funding for maternal and child health programs or medicaid budgets or legislation which cap or prohibit providing expanded services in those States which have minimum medicaid programs may remove or seriously damage the infrastructure of health funding for newborn intensive care to large areas of this country.

Tremendous strides have been made in the last decade in decreasing the newborn mortality rate; we humbly request your serious attention to these issues so that we may continue to demonstrate the progress of the last decade.

Let us not make infant Downing's tragic death when there was "no room in the inn" be in vain, but rather, may this tragedy provide insight to the dilemmas which confront legislators, physicians, and hospital administrators of today for infants requiring special care. The need is to provide access to available high quality neonatal intensive care so that the tragedy of wasted life or potential may be avoided.

I have asked Dr. Donald Eitzman, distinguished service professor of pediatrics from the University of Florida in Gainesville to share the results; in other words, are these normal children produced in the neonatal special care?

Dr. Eitzman.

TESTIMONY OF DR. DONALD EITZMAN

Dr. EITZMAN. I have three graphics attached to the back of the text there.

It includes, first of all, a map of the State of Florida, which shows the distribution of perinatal centers within the State. There are currently nine centers and with the current funding which the State has appropriated this last session, there are more State dollars in our program than any other program, almost any other program in the United States.

What happens to the babies that graduate from these centers? Right now the mortality rate is low, so that we are saving more babies that were saved before. But is it worth it? These are some questions that are frequently asked.

We have evaluated the graduates of each neonatal center since the program started in 1974, and if we look at the highest risk group, which is those babies born with the birth weight less than 3 pounds, then taken as a group, their developmental scores are not significantly different from another group of babies born at term, which was the groups used to standardize the testing system that we are using. So that we think there is a lot of evidence to suggest that, yes, it is worth it.

Is there a cost savings from the amounts of money that the State is currently putting into it? Yes, we think that we can show this too. So, that when you look at the number of babies who were living that would not have lived and what is the percentage of these babies that are requiring some sort of custodial care, then it is significantly less.

That last graph attempts to add these up and show that, yes, the State is saving money. In that last column where we show a savings of $33 million, we have estimated that throughout the program we have instituted a lot of parenting, increased contact with the children coming out of this program, and this is being funded through the area of developmental programs in the State. This would be an additional expenditure. However, again the total savings is approximately $33 million.

Most of the time in medicine we talk about survivals of 1 or 5 years, if you are talking about some cure of cancer. We are not talking about 5-year survival in this group, we are talking about

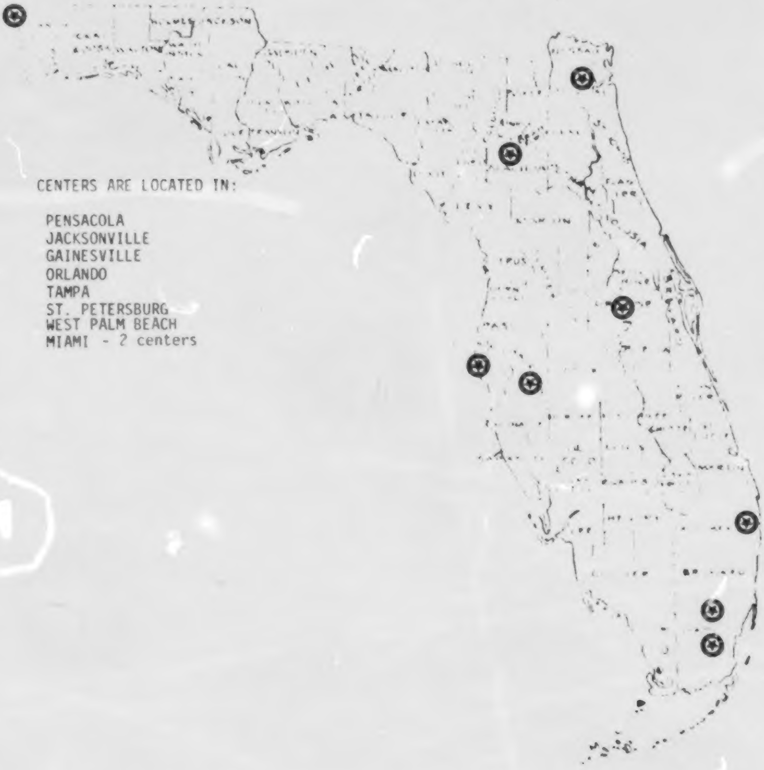
60- and 70-year survival rates. So, we are dealing with the potential future of America, and I think that if you are talking about reducing medicaid funding, it is going to have a significant impact on preventing some child from getting the sort of care that he might otherwise get.

Thank you.

[The graphs referred to follow:]

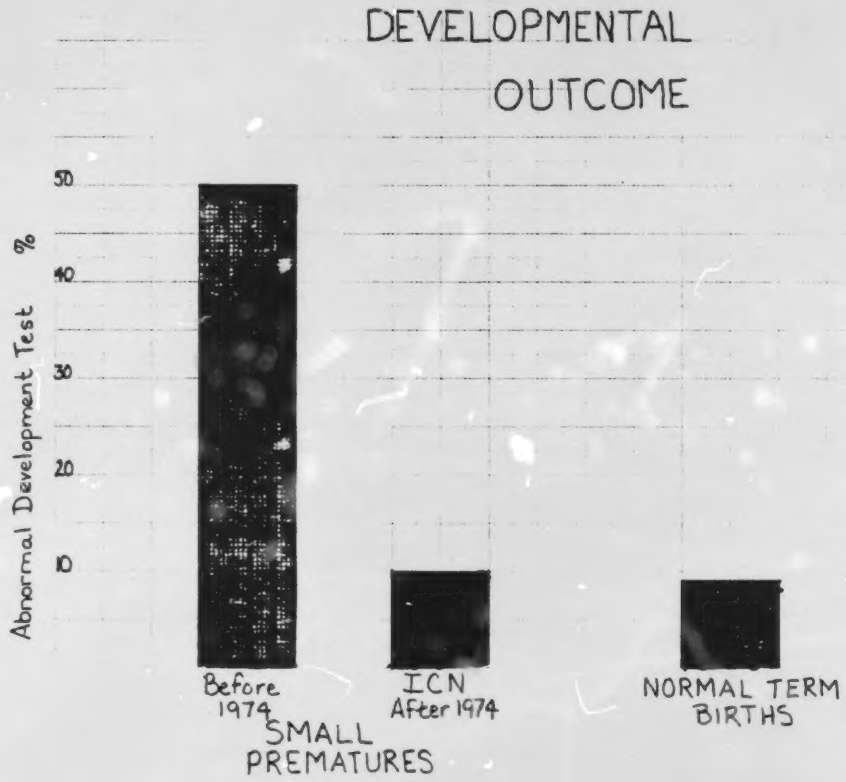
STATE OF FLORIDA

REGIONAL PERINATAL INTENSIVE CARE CENTERS



CENTERS ARE LOCATED IN:

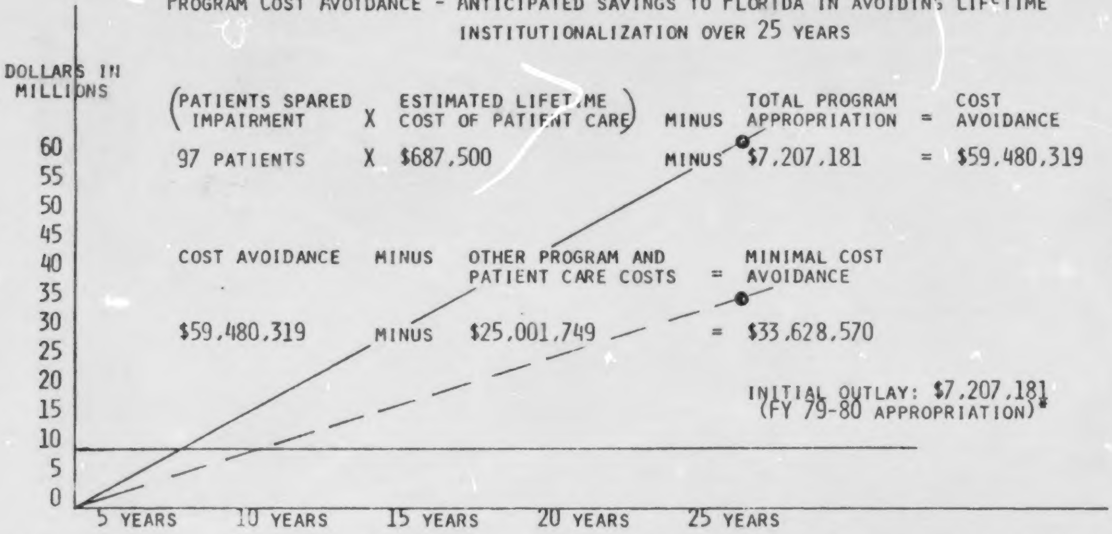
PENSACOLA
JACKSONVILLE
GAINESVILLE
ORLANDO
TAMPA
ST. PETERSBURG
WEST PALM BEACH
MIAMI - 2 centers


DEVELOPMENTAL
OUTCOME
Abnormal Development Test %
50
40
30
20
10
Before 1974
ICN After 1974
SMALL PREMATURES
NORMAL TERM BIRTHS

89-282 0—82—2

1979-1980 PROGRAM OBJECTIVE EFFECTIVENESS: DEVELOPMENTAL EVALUATION COMPONENT

PROGRAM COST AVOIDANCE - ANTICIPATED SAVINGS TO FLORIDA IN AVOIDING LIFETIME INSTITUTIONALIZATION OVER 25 YEARS



(PATIENTS SPARED IMPAIRMENT X ESTIMATED LIFETIME COST OF PATIENT CARE) MINUS TOTAL PROGRAM APPROPRIATION = COST AVOIDANCE

97 PATIENTS X $687,500 MINUS $7,207,181 = $59,480,319

COST AVOIDANCE MINUS OTHER PROGRAM AND PATIENT CARE COSTS = MINIMAL COST AVOIDANCE

$59,480,319 MINUS $25,001,749 = $33,628,570

INITIAL OUTLAY: $7,207,181
(FY 79-80 APPROPRIATION)*

*TOTAL APPROPRIATION INCLUDES NEONATAL, OBSTETRICAL, AND DEVELOPMENTAL EVALUATION FUNDING.

PDCM

Mr. **Gore**. Thank you very much.

I will recognize myself for 5 minutes under the rules.

What you have just told us there is that if you take out the infants who would otherwise die without the neonatal intensive care units, you subtract the ones that would die without this care, there are enough of the remainder that would be mentally retarded or otherwise impaired that would generate expenses for the State of Florida so large that it is not only humanitarian to have those units, it is also cost effective; is that the thrust of what you just told us?

Dr. **Eitzman**. Yes; that is what we would like to prove with these sorts of statistics.

We are saving more babies, but the babies that we are saving are better off than the babies that used to live regardless of what kind of care they got.

Mr. **Gore**. Thank you.

Dr. Curran, you have testified that this child would have had a 70-percent chance of surviving if he had been admitted to the neonatal intensive care unit, is that correct?

Dr. **Curran**. That is in general the experience with this size infant in this country.

Mr. **Gore**. Now, you also testified that the Tampa General Hospital had sufficient personnel and space ready, willing, and able to deal with the admission and care of this child on July 2, 1981, is that correct?

Dr. **Curran**. In my medical opinion, sir.

Mr. **Gore**. Well now, the reason the child was not admitted to the hospital was because it didn't bring money into the world with it?

Dr. **Curran**. No; I do not think that was an issue. It was simply a policy that no children could be admitted until the services were brought down to a smaller level.

Mr. **Gore**. So, there wasn't enough room in the budget for it?

Dr. **Curran**. Yes, sir, that would be the way the hospital's governing board viewed the situation.

Mr. **Gore**. Now, there was room in the unit, there was a bed available, there were personnel able to care for the baby, but the governing board, in a decision that was made without input from the medical staff, decided that the budget would not permit them to care for this infant?

Dr. **Curran**. That is correct, or any other infants.

Mr. **Gore**. All right.

Are you aware of any hospitals within the Tampa area that require financial screening tests before admission to a neonatal center?

Dr. **Curran**. Yes.

Mr. **Gore**. Which ones?

Dr. **Curran**. Women's Hospital.

Mr. **Gore**. Women's Hospital. Now if an infant is brought there needing intensive care, they stop the mother at the desk and require some assurance that she has enough money to pay for the intensive care?

Dr. **Curran**. That is basically what is true. When we talk about a newborn being referred into their unit for care, it is a matter of public record that they require $15,000 deposit in advance.

Mr. **Gore**. Deposit in advance.

Now this baby boy Downing case was just a rare isolated instance that probably won't ever happen again?

Dr. **Curran**. No, sir.

Mr. **Gore**. Is this the kind of thing that happens regularly.

Dr. **Curran**. All too frequently, sir.

Mr. **Gore**. How many infants a month, in your State, go through this experience?

Dr. **Curran**. I think I would have to say I do not know with regard to the finances, per se, but in terms of infants for whom their doctors seek care, born in an outlying facility, in the month of June 1981, there were 10 infants who died while awaiting placement.

Mr. **Gore**. Ten in 1 month. But we are going to hear from other witnesss that this is happening in other States all around the country. And it is something that I really wasn't aware of until I read the accounts of this instance in Florida. I guess I should have been. But I really don't think very many Americans are aware that this happens on such a regular basis around the country.

When I was in college, I took an anthropology course one time and read about some primitive tribes in the history of the world that practiced infanticide when they decided there were no longer enough resources to support a larger tribe. And it seems to me that this really amounts to institutional infanticide. We don't have the resources to provide intensive care for infants that need intensive care, so they are turned away or their mothers are asked for a $15,000 deposit in advance.

And evidently it happens—well, 10 a month in Florida; we don't have firm estimates but it seems safe to say that there are probably hundreds of such cases in the United States. And I do not think the American people want to see this continue.

Dr. **Eitzman**. Could I say just one statement. I don't want to minimize the figures that you have estimated here, but the 10 figure is a recent occurrence. Say a year ago it was probably zero or one. So this is something which has grown over the past period of months. It is a phenomenon we have seen in Florida because of increasing population and immigrants coming into south Florida which have made the problems particularly intense.

Mr. **Gore**. Do you think the problem may get worse with further cutbacks in medicaid funding?

Dr. **Eitzman**. It certainly will, and we are doing everything we can to increase our facilities and capability to handle it at the moment.

Mr. **Gore**. Thank you very much.

I would like to recognize Mr. Marks for 7 minutes.

Mr. **Marks**. Thank you, Mr. Chairman.

I just have a few questions for you, some of which are for our own edification about this particular incident of the Downing child.

We note in looking at the map that there was a facility available perhaps at St. Petersburg as well as Tampa, is that correct?

Dr. **Curran**. That is correct.

Mr. **Marks**. I am just curious, was there some reason why you didn't mention St. Petersburg?

Would there have been a problem in getting the child to St. Petersburg and would it not have been closer?

Dr. **Curran**. The distances were approximately equal. St. Petersburg was contacted and were not able to care for the child as their facility was totally utilized. That was true for each of the other centers participating in the State program. We do move infants distances as great as Miami to Pensacola in that State.

Mr. **Marks**. I see.

I assume you have air transportation available to do this?

Dr. **Curran**. Yes, sir. It is sometimes patchwork but we do move patients long distances if that is the only place where there is a bed available.

Dr. **Curran**. The Government's MAST program, [Military Assistance to Safety in Traffic], has been a major contributor to the movement of infants in that State.

Mr. **Marks**. Again, had the child in fact been taken, may I ask you this: If the child had been taken at all, would the child have been moved by car and/or plane?

Dr. **Curran**. This infant would have been moved by a newborn carevan, a specially equipped emergency medical service vehicle.

Mr. **Marks**. Approximately how long would it have taken from the time contact was made to reach the hospital either at Tampa or at St. Petersburg?

Dr. **Curran**. I think there is another part, we would have had a physician, nurse, and respiratory therapist at the infant within 1 hour of the call. They would have been able to provide care equivalent to that within the hospital in that unit and bring the child back in roughly 1 hour more. Potentially by 7:30 to 8 o'clock that morning, this child could have been in a hospital environment in a newborn intensive care unit.

Mr. **Marks**. Was there not medical care available to go to the child's home—strike that for a moment.

When the call was placed by the parent or parents of the child, to whom did they—with whom did they get in touch?

Dr. **Curran**. The call was placed by the hospital in Dade City. The child had been brought by the local emergency medical service to the facility.

Mr. **Marks**. OK. And in that facility it did not have the facilities to take care of the child?

Dr. **Curran**. Not at all, sir.

Mr. **Marks**. They didn't refuse to take care of it, they in fact did give the child some service, I assume.

Dr. **Curran**. Minimal supportive care.

Mr. **Marks**. That which they had available?

Dr. **Curran**. Yes, sir.

Mr. **Marks**. And then a call was made, this would have been—the child was born I think you said about 5?

Dr. **Curran**. That is correct.

Mr. **Marks**. The call was then made within the hour?

Dr. **Curran**. About 28 minutes after birth.

Mr. **Marks**. And then it was—it was determined there wasn't space available either at Tampa or St. Petersburg?

Dr. **Curran**. The entire State was canvassed and the return was made within 8 minutes.

Mr. **Marks**. Let me ask you this question, Dr. Curran: Had the child in fact been taken to either St. Petersburg or Tampa, are you satisfied that they would not have admitted the child or made some space available, done something to try to take care of this particular child in this particular case?

Dr. **Curran**. I can tell you that as a physician that if that child had come to the hospital, we certainly would have cared for that child regardless of the rules and regulations.

Mr. **Marks**. Yes; so I guess the question is then, who made the decision not to take the child to either Tampa or St. Petersburg, under the circumstances as you have just told us, that the child would have been taken care of once the child got there.

Dr. **Curran**. It is a little confusing whether you say that is the administrator on call who refused to allow the child to be admitted or whether it is the physician who is on call who adhered to the administration's policy?

Mr. **Marks**. OK. Then our understanding is that when the call was made and the word came back that there wasn't anything available, had in fact someone made the decision to take this particular child to either St. Petersburg or Tampa, in your opinion they would have received—the child would have received care?

Dr. **Curran**. Yes, sir.

Mr. **Marks**. And perhaps you have given us the answer but I am curious who made the decision, in spite of the fact they were told there isn't any room, not to take a child either to Tampa or to St. Petersburg.

Dr. **Curran**. I am afraid one would have to say it was one of my associates who would not override the direct order from an administrator not to take that child into the unit.

Mr. **Marks**. I see.

If in fact the denial of access, as I understand your testimony, was not in fact a question of the Downing family's ability to pay, rather it was a decision to cut back costs regardless of the type of payment; would that be a fair statement?

Dr. **Curran**. That is absolutely true.

Mr. **Marks**. Then I ask you this question, again for you to enlighten us: If that is in fact the case, would the proposed Federal limit on expenditures—would not the proposed, maybe put it that way—Federal limit on expenditures not have as severe an impact on the hospital's decision, or would it?

Dr. **Curran**. In the case of this particular hospital, this is past history, their decision. I do think that it would be a potent influence on their either continuing that policy or their reviewing their policy and going back to business as usual if there were increased funding.

Mr. **Marks**. Thank you very much, Mr. Chairman.

Mr. **Gore**. Mr. Leland is recognized for 7 minutes.

Mr. **Leland**. Thank you, Mr. Chairman.

Dr. Curran, can you tell me what kind of doctor you are?

Dr. **Curran**. Well, that is an unusual question. I would like to think that I really care about kids, that I enjoy my work, and my whole goal and mission is to try to set up a service there in Tampa with the new medical school and to provide care up until this incident to every child if we could physically care for the infant, and that is why we commonly cared for 33 kids at one time in a unit supposedly only 18 in size.

Perhaps I am a little bit liberal in my philosophies and at variance with my hospital administration.

Mr. **Leland**. Before you got to be—when you were sworn in as a doctor you had to take an oath, is that correct?

Dr. **Curran**. Yes, sir.

Mr. **Leland**. Called the Hippocratic oath?

Dr. **Curran**. Yes, sir.

Mr. **Leland**. Can you explain the sense of what that is?

Dr. **Curran**. In essence it says that you will try and treat all patients, try to treat them to the best of your ability. And that is really, I think the essence of the oath.

Mr. **Leland**. Does it imply or allude to the right of every person to receive the services that you were trained to impart to your patients?

Dr. **Curran**. I think it does, very definitely, if I am in an environment which permits me to do so or that I can work with that environment to provide that service.

Mr. **Leland**. And all doctors have to submit themselves to the Hippocratic oath, is that not correct?

Dr. **Curran**. Well, I think it is primarily done as part of the tradition of medicine, but that it is—they are principles, generally subscribed to.

Mr. **Leland**. Do you think that the hospital—and I am not just singling out any one person—but the hospital that was the perpetrator of the problem that we talk about this morning as this dramatic example, is subject to that same Hippocratic oath, subject to treating patients to the ultimate of their ability?

Dr. **Curran**. In general terms, yes, I do. Certainly for emergency medical care, if you have the resources available, to deliver it.

Mr. **Leland**. Then they violated, in fact, the essence or the principles of the Hippocratic oath by this denial?

Dr. **Curran**. In my opinion, yes, and they have placed that burden on the physicians also.

Mr. **Marks**. Excuse me, I wonder if my colleague would yield for just a moment?

Mr. **Leland**. Be glad to.

Mr. **Marks**. The question of my colleague from Texas is an interesting one, and your answer more so, because I didn't understand your answer to me along these same lines as being quite the same.

I thought you told us that had the child in fact been transferred to Tampa or St. Petersburg, the child would have received the care necessary, in spite of the fact that you were told over the phone or whatever it is that there were no beds available.

Dr. **Curran**. If I may clarify, there is additional information.

When we move a small premature infant by and large particularly in the rural area, we send the team to the infant, we then move the baby back, what we call afterstabilization. What I was replying to you is that if the physician in Dade City placed that baby in an incubator and personally accompanied that child in their ambulance and came posthaste to Tampa, we would have delivered care to that infant regardless. I, however, was prohibited from dispatching a team to the patient.

Mr. **Marks**. Sorry.

Dr. **Curran**. I was prohibited from dispatching a team to go to the patient to bring the patient back; in other words, hospital employees.

Mr. **Marks**. You were prohibited from doing that?

Dr. **Curran**. Yes, sir.

Mr. **Marks**. By——

Dr. **Curran**. Again the hospital administrator, the assistant administrator for nursing.

Mr. **Marks**. I see. I would appreciate it if the chairman would give my colleague an additional minute or so since I have taken his time.

Thank you.

Mr. **Leland**. That is all right.

I am particularly struck by that case because it seems it is one of the most glaring examples of the true denial of a person's right to life, particularly if that person is alive and breathing, once he is born.

I am really puzzled here because it seems to me that you are under the authority of a hospital administrator that doesn't necessarily believe in the same principles that you believe. This Member of Congress does in fact believe the same as you believe, I think from what I have gathered from what you have said.

Are hospital administrators and people of that level of authority in any way subject to the same kinds of principles that you are subject to?

Dr. **Curran**. Not in a strict legalistic sense unless it falls under emergency care statutes.

Mr. **Leland**. Then they don't necessarily have the same commitment or have to have the same commitment to life and life-support systems imparted to those people who are considered to be patients of a particular hospital or potential patients, is that correct?

Dr. **Curran**. In this instance we reviewed it multiple times since the episode and they do not have that commitment.

Mr. **Leland**. In your opinion, are they in essence subject to the fiscal responsibility of maintaining the hospital in the black, so to speak, as opposed to truly imparting the kind of qualitative services that I hear you saying that should be provided?

Dr. **Curran**. I think a board of directors must operate a hospital in a financially responsible manner.

However, I do not understand all these details as a physician and when I understand that that hospital has uncollectibles of approximately $34 million per year, why are programs for mothers and infants cut first as an economy measure?

Mr. **Gore**. Will the gentleman yield?

Mr. **Leland**. Be glad to.

Mr. **Gore**. I think an appropriate followon question which our witness can't answer for us is whether or not individuals in State legislatures around the United States, and individuals who serve in this Congress, share the principles and commitments that Dr. Curran has made in his career.

Mr. **Leland**. Certainly we won't ask you to respond to that, but I think it is a very good point you made.

The bottom line to this is that as a physician you are committed to providing or facilitating the opportunity for life wherever you can.

Dr. **Curran**. Yes, sir.

Mr. **Leland**. Do you think that the Framers of our Constitution should have provided a provision that would have afforded the right to health care services for all of the people of this country as opposed to the privilege? Because we understand that any kind of service that we have, as well as goods, in this country are particularly costly and thus we have to maintain certain standards of affordability. But at the same time, it seems to me, this man's opinion, that we should have afforded the right to health care services as opposed to the privilege for only those who can afford health care services.

Dr. **Curran**. I agree, sir.

Mr. **Leland**. OK. One last question.

Are you familiar with the child health assurance program, CHAP as it is called?

Dr. **Curran**. Not very familiar with it, sir.

Mr. **Leland**. CHAP was primarily designed to accommodate more and more—well, more particularly young people, children of our society, to be eligible or become eligible for medicaid services. CHAP was passed in the House and was killed for various and sundry reasons in the Senate.

This year CHAP probably could not pass in the House of Representatives because of the budget constraints that the new administration has imposed on us and because of the so-called attitude or the environment created by the conservative character of this Nation.

In your opinion, do you think we should be trying to make more children available to medicaid as opposed to cutting the numbers down of people who are now eligible for medicaid?

Dr. **Curran**. Yes, sir, I do.

Mr. **Leland**. Thank you.

Mr. **Gore**. Mr. Walgren?

Mr. **Walgren**. Thank you, Mr. Gore.

Do I understand it correctly that if these parents had been able to pay they still would have been denied access to that hospital because there was an 18-bed cap?

Dr. **Curran**. That is correct, in that hospital.

Mr. **Walgren**. And so even though the hospital would have been out nothing and there would be no additional cost to the hospital's uncollectibles, the hospital still refused that service?

Dr. **Curran**. That is correct.

Mr. **Walgren**. The theme of somebody violating their—the medical professional's obligation certainly seems to run deep in this question.

As you said, somebody refused to override the administrator's order. Was it a physician that refused to override the administrator's order?

Dr. **Curran**. Yes, basically by way of the rules of the medical staff which could result in suspension or expulsion.

Mr. **Walgren**. So the physician is certainly in a terrible dilemma?

Dr. **Curran**. Yes, sir.

Mr. **Walgren**. What is the makeup of the board? Are they physicians?

Dr. **Curran**. There are no physicians on the board, they are primarily merchants.

Mr. **Leland**. Will the gentleman yield?

Mr. **Walgren**. Yes.

Mr. **Leland**. There is no one at all on the board who is a physician?

Dr. **Curran**. No.

Mr. **Walgren**. That is unusual.

Let me ask then just to clear up whether this is an unusual case. Is there a shortage of neonatal beds in Florida?

Dr. **Curran**. Yes, sir.

Mr. **Walgren**. How do you measure that shortage? Can you estimate it?

Dr. **Curran**. It is hard for me to estimate. We have general rules that we need a center of approximately 15 beds for each 10 to 12,000 live births in the State. Currently we have, depending on whether one center has totally withdrawn and firmly withdrawn from the program, 133 beds in that State, and it looks like it needs 180.

In addition, I serve as the medical director of the careline so I do see all the requests of infants who cannot be promptly placed. It does look as if we need one more center, particularly in the south part of the city where we have the concentration of population.

Mr. **Walgren**. Has the Federal Government ever been involved in a program to encourage States to create such centers?

Dr. **Curran**. Only through the legislation with regard to HSA's in establishing principles for them

Mr. **Walgren**. So there is no Federal program specifically aimed at requiring this balance of neonatal bed versus the other kind of bed or even to provide such funding?

Dr. **Eitzman**. There was some legislation several years ago which included neonatal intensive care units among a block grant part of the program to mother-infant care fund.

Mr. **Walgren**. Is there a comparable Federal program for kidney dialysis?

Dr. **Curran**. There is.

Mr. **Walgren**. Do you have any idea the amount of money we spend on kidney dialysis in Florida compared to neonatal provision of services?

Dr. **Curran**. I think it is a great deal more but I do not have those figures.

Mr. **Walgren**. It would be a multiple of the amount invested in neonatal?

Dr. **Curran**. I believe so.

Mr. **Walgren**. And that is federally mandated, is that correct?

Dr. **Curran**. Yes, sir.

Mr. **Walgren**. The legislature has doubled the funding from the State contribution to the neonatal centers in the last several years, is that correct?

Dr. CURRAN. In the last year it has doubled the funding.

Mr. WALGREN. And that still is unable to keep up with the costs?

Dr. CURRAN. As the hospital administrators view it, yes, that is their policy.

Mr. WALGREN. What do you mean, as the hospital administrators view it?

Dr. CURRAN. Well, again as I have said, as a physician I am not sure I understand all about hospital accounting. I think that each of those facilities has a different cost accounting method; there is not a uniform method to ascribe costs, not charges; and that the State of Florida, through its Department of HRS, is trying to devise a uniform cost document so that true cost data can be derived.

We have a lot of charge data but not cost data.

Mr. WALGREN. I see. So it is conceivable that the action to limit it to 18 beds is not related to neonatal costs at all, but rather, the overriding pressure on the hospital as a general facility.

Dr. CURRAN. No, I do not think that is true, as explained to me by those making the decisions. They view this as one area where costs are outstripping their ability to collect.

Mr. WALGREN. The 10 deaths in the last month are apparently unusual in Florida, is that correct?

Dr. CURRAN. I believe that is the highest month yet.

Mr. WALGREN. How unusual is that?

Dr. CURRAN. I think it is a harbinger of the future, and the mood that has come about, of restricting access. I believe this is the first month where we have seen that level of loss.

I can tell you that if I look at the whole previous year, fiscal year of July to June in 1980–81, that there were about 800 infants for whom requests were made who couldn't be placed in their nearest centers in the State of Florida, somewhat over 600 of them were placed. Of infants not placed, about one-third died; in the month of June it was 47 percent, of those who couldn't be placed.

Mr. WALGREN. How many of those who were placed died? What percentage of those placed died?

Dr. CURRAN. Dr. Eitzman will correct me if I am mistaken, but if we look at our overall infants transported, I think we are looking at 18 percent die.

Mr. WALGREN. Much higher for those not placed?

Dr. CURRAN. Two and a half times.

Mr. WALGREN. The suggestion was that the reason for his 10 figure was with the influx of the immigrants into south Florida that this might explain the unusually high number. How many of those 10 were Haitians or Cubans?

Dr. CURRAN. I cannot answer that.

The State's HRS is studying that question.

Dr. EITZMAN. The majority of babies that we have personally transported from south Florida are Spanish-speaking parents.

Mr. WALGREN. What would that—when you say the majority, the number transported from south Florida, how would that compare with the number transported over the State as a whole?

Dr. EITZMAN. That would be considerably different, but during this month when we have had such a crunch from south Florida, we transported approximately half of the babies that needed to be moved from south Florida, which was a total of 7 or 8 for 1 month for us, and the majority of those babies, 4 were Spanish-speaking. For our own population that is considerably different.

Mr. **Walgren**. I certainly appreciate the situation you find yourself in. It is not unusual and I think it will accelerate.

In Pennsylvania we have seen a version of this in the capping of administrations to skilled nursing homes. The result is that patients have no facility to go to and therefore I am sure die much sooner in their homes from lack of treatment than they would if they had access to a nursing home, and the only explanation for that is the State did not feel it had the funds to pay for medical costs, documentably necessary medical costs.

I just think there is a basic question of the level of government on which we pay for it; the States have very regressive tax structures. In Allegheny County we funded our nursing home basically on a property tax. The State has a flat income tax, that is pre-1921, in its social ethic.

I just think the present administration is going 180 degrees in the wrong direction. I wish that this kind of case would develop the sense of outrage among the Congress that would provide funding on the Federal level for these kinds of programs.

So I appreciate your testimony very much.

Mr. **Gore**. You said there were 200 infants for whom room could not be found in neonatal intensive care units last year in Florida; is that correct?

Dr. **Curran**. It was approximately that.

Mr. **Gore**. Sixty to seventy of those died?

Dr. **Curran**. About one-third.

Mr. **Gore**. Of the remaining two-thirds, how many suffered mental retardation or other lasting impairments?

Dr. Eitzman, what would statistics lead you to surmise about that?

Dr. **Eitzman**. The statistics are not good until 2 years of age. Based on past experience, it would have been 10 percent of them who would have suffered some sort of compromising medical or mental situation.

Mr. **Gore**. Based on your analysis, the lifetime care for that 10 percent of the remainder is probably more in dollars and cents than the cost would have been to provide neonatal intensive care to prevent the retardation or other lasting impairments?

Dr. **Eitzman**. Yes, sir.

Mr. **Gore**. So it is not just a matter of people standing up for a principle, and infants in need of care suddenly to be given that care. It is also a matter of hardnosed economics. The public saves money by doing this.

I yield to my colleague, Mr. Coats.

Mr. **Coats**. Thank you, Mr. Chairman.

Dr. Curran, I appreciate your willingness to testify on this matter today and provide us with this information. I don't think anyone on this panel wants to think of themselves as insensitive to the right of all children, even the preborn, to participate in and live in this society.

I am a little concerned. Just to clarify for the record here, I am concerned about some of the picture that is developing here in terms of the insensitivity of the administrators or the board of

Tampa General Hospital. It is difficult for me to imagine an administrator, an assistant administrator, or a board of directors of that hospital, coldly calculating—strictly for economic reasons—that a certain number of infants are going to be denied access to the hospital, or will die in the streets, or in the home where they were born.

You, however, seem to indicate that this is the case. I want to make sure that we are clarifying this for the record. We are talking about life in this instance; we are talking about life for the preborn. We are also talking about the lives of the administrator and the assistant administrator and the board members of Tampa General. I want to make sure that the picture we are painting here, or the allegations we are making, are at least fair to these individuals.

Are you saying that all they think about is profit and loss, and when they look at the balance book, they see more money flowing out of this hospital than flowing in, and they are looking for economies, and if that results in babies dying, then so be it? Is that the implication that you want to leave?

Dr. CURRAN. I would like to just correct it a little bit, and then come back to the implication. The correction is, I think that we have to be careful in terms of levels of responsibility. There is a Hillsborough County Hospital Authority, which are lay people appointed to make policy decisions. There then is a hospital administration which is charged with implementing the policy decisions they receive. I do not think any of the administrators, the people in day-to-day involvement in the hospitals, are comfortable with this decision. However, they have been given a very flatout policy that they must implement. I think there may be other implications which are that perhaps the governing board felt they could secure some political advantage in the State with regard to funding. I, however, am not privy to any of that. Basically, as explained to me on several occasions by the chairman of that board of directors, this is purely a financial decision.

Mr. COATS. If I understand your statement correctly, what you are saying is that the inference that the administrator and assistant administrator simply are irresponsible or unresponsive to the medical community is not necessarily the case; that they are following the mandate of the board in terms of policy laid down to them.

Dr. CURRAN. That is correct.

Mr. COATS. Is that policy specific in terms of reduction of services for the neonatal care unit, or was it a broader thing, saying that we need to save this amount of dollars?

Dr. CURRAN. That is specific for the neonatal care unit.

Mr. COATS. Earlier, you testified, I think, that the hospital had $34 million in uncollectibles. Was this for the previous year?

Dr. CURRAN. Yes, sir.

Mr. COATS. Do you have an idea of what areas those uncollectables result from?

Dr. CURRAN. I really don't have all of those details. That includes adults as well. Somewhere around $2½ million of that is ascribed to neonatal care. You must recognize that the hospital calls uncollectables also contractual writeoffs for such programs as medicaid.

They are not bad debts per se. They are the difference between charges and collections.

Mr. **Coats**. How much of that $34 million is actually a loss, or do you have any idea?

Dr. **Curran**. I don't know.

Mr. **Coats**. I guess we would all recognize that if $34 million is going out the door as a net loss every year, something has to be done. Either we have to have more public funding, or we have to raise fees for those able to pay, or we have to cut back on services—one of those options.

Dr. **Curran**. They have announced they have had a profitable year, actually being in the black, in spite of that.

Mr. **Coats**. In spite of the $34 million uncollectibles?

Dr. **Curran**. Yes, sir.

Mr. **Coats**. You have no idea which areas of the hospital, other than the $2½ million for neonatal——

Dr. **Curran**. No, I don't, sir.

Mr. **Coats**. Do you think it might be a wise policy on the part of the board, if they directed cutbacks in areas where they were having trouble collecting rather than, say, more critical care areas such as neonatal care, emergency care, this type of thing?

Dr. **Curran**. I would answer this by saying any general hospital is going to have areas where they probably make a profit. They are also going to have service areas where they are going to have losses. I think they must balance the two of them.

Mr. **Coats**. Let me get back a little bit to the board question now, the board that is determining the policy, and evidently very specifically determining the policy, because they have directed a specific cutback in neonatal care operations until so many beds are available, and so forth.

You are saying that the board really doesn't have the expertise to make this decision; is that a fair statement on my part?

Dr. **Curran**. I don't think they have considered all the human issues. There are moral and ethical dilemmas involved here as well.

Mr. **Coats**. I couldn't agree with you more on that.

The board is made up of merchants from the community?

Dr. **Curran**. Primarily gentlemen in business in the community; yes, sir.

Mr. **Coats**. No one on the board with a medical background?

Dr. **Curran**. No, sir.

Mr. **Coats**. This is a nonprofit hospital; is that correct?

Dr. **Curran**. That is correct.

Mr. **Coats**. What is the motivation for these businessmen or merchants to serve on the board? If I were a businessman in Tampa, why would I want to serve on the board? It sounds like a lot of headaches.

Dr. **Curran**. At the moment, I don't know that you would want to.

Mr. **Coats**. There is no financial reward?

Dr. **Curran**. No, sir, there is not.

Mr. **Coats**. As a nonprofit institution, of course, there are no stock dividends or return on bonds.

Dr. **Curran**. No, sir. This is a public-service commitment.

Mr. Coats. Could we assume that the board members have some altruistic motives; they are interested in human needs? I am sure it requires a lot of time.

Dr. Curran. I think some of them very definitely do.

Mr. Coats. Has anything been done since this incident to sit down with either you or the administrators—to sit down with board members—to outline or at least to explain that the policy laid down was perhaps not the correct policy?

Dr. Curran. Yes, we have met on two occasions with the chairman of that authority.

The response is no change in policy; it will remain as it is.

Mr. Coats. What reason did they give for that?

Dr. Curran. Again, financial.

Mr. Coats. Did they indicate in any instance there was no other option or no other way to go? Did you suggest to them that perhaps if the question is financial, maybe they ought to direct their efforts in another area?

Dr. Curran. Yes. I definitely have, and we actually have records substantiating over 1-year attempts to try and prevent this type of situation from developing by working with that board, but it had been rejected, and I am not at all clear why.

Mr. Coats. Did they make an effort to explain to you why this is the case, what their financial difficulties were?

Dr. Curran. Yes, in part. They also freely admit it was somewhat of a snap judgment because data was not available to them until 3 days before their announced decision.

Mr. Coats. But it is no longer snap judgment?

Dr. Curran. That is correct.

Mr. Coats. But their policy is still the same?

Dr. Curran. That is correct.

Mr. Coats. They are totally intransigent on this issue.

Dr. Curran. That is correct.

Mr. Coats. With no explanation as to why.

Dr. Curran. That is correct—other than what I have told you. While this may not be the place to announce it, it is the subject of public interest litigation in that city.

Mr. Coats. Perhaps we should leave that, then, to the litigation.

Mr. Chairman, I might suggest that in the future we ought to have the board here. It appears that this is where the crux of the problem lies. It would be helpful to us, I think, in evaluating this, determining whether this is a national problem deserving national attention, or perhaps a local problem with some misplaced board members.

We ought to have a spokesman from that board here to explain why they would make that kind of a decision. I can't imagine them being that insensitive—if the hospital is making a profit, as you say; if financial problems really are not the case. How anybody could deny treatment to a 2.6-ounce baby at its doorstep is beyond my comprehension.

Mr. Gore. The gentleman's time has expired.

I might say we will have other witnesses in a moment who will tell us that this is indeed a national problem and that the decisions made by this board were influenced heavily by pressures that are commonly felt by hospital boards throughout the United States.

I would like to recognize counsel for a brief question.

Mr. SEGAL. Dr. Curran, isn't it the situation that when the board was faced with this decision, they had a large set of uncollectibles, and bills that were not adequately reimbursed, and that one of the major causes was lack of sufficient resources provided by the medicaid program to begin with?

Dr. CURRAN. That is true, because medicaid is a supplement to the State general revenue dollars. They are separate, but they are very much a participant in the provision of this care.

Mr. SEGAL. So the fact the medicaid funds helped create this dilemma and with an impending medicaid cap at the Federal level, would your assumption be that the situation would get exacerbated?

Dr. CURRAN. Yes, sir.

Mr. SEGAL. Thank you.

Dr. EITZMAN. The rest of the centers throughout the State are all losing money, so there are eight hospital administrator groups who are willing to support this and accept it, and the State mandates that each center has 18 beds. Tampa now has 18 beds. Before, they had more than 18 beds, so that they are strictly—legalistically, they are complying with what State aid they had to have.

Mr. GORE. The first hospital which was referred to—is it Petersburg?—it was really filled up; is that correct?

Dr. EITZMAN. That is right.

Mr. GORE. Did it have more beds at one time?

Dr. EITZMAN. No.

Mr. GORE. I would like to thank you both.

This hearing would not be taking place except for the death of this baby boy, Downing, but it is also true this hearing would probably not be taking place—and further investigations I would hope to engineer would not be taking place—except for Dr. John Curran, et cetera, and I would like to thank you for your courage and forthrightness, Dr. Curran. I am sure you don't think of yourself in these terms, but in 4½ years of conducting investigations, I think I have begun to recognize the ring of truth and honesty and forthrightness when it comes out, and when somebody has the guts to just quietly tell the truth, I am sure it is uncomfortable for you to say some of these things about the policies of the hospital, and I know it takes a good deal of courage. I just want to congratulate you on being willing to stand up and just say the right thing.

Thank you. And thank you, Dr. Eitzman, and others like you in the State of Florida, who have over the years put together a very impressive system that unfortunately is in great danger in the current environment.

We are now going to call a panel of witnesses, a panel of three people, each of whom has provided really excellent testimony, and I want to thank them in advance.

I would like to call Dr. Robert Goldenberg, from the University of Alabama Medical School; Ms. Vivian Mendez, from the North Central Legal Foundation in Dallas, Tex.; and Karen Davis, from the Johns Hopkins School of Public Health.

If all three of you would please come to the witness table. If you don't mind, would you stand and raise your right hand?

Do you swear the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

Dr. GOLDENBERG. I do.

Ms. MENDEZ. I do.

Dr. DAVIS. I do.

Mr. GORE. Thank you in advance for providing such excellent testimony. Without objection, the entire text will be put in the record following your testimony.

Dr. Goldenberg, we will begin with you. You may proceed.

TESTIMONY OF DR. ROBERT GOLDENBERG, OBSTETRICIAN, UNIVERSITY OF ALABAMA MEDICAL SCHOOL; VIVIAN B. MENDEZ, NORTH CENTRAL LEGAL SERVICES, DALLAS, TEX.; AND KAREN DAVIS, PROFESSOR, JOHNS HOPKINS SCHOOL OF PUBLIC HEALTH

Dr. GOLDENBERG. I come before you today in two capacities. First, I am an obstetrician and work providing prenatal care and delivery services, mostly to poor women in a major medical center in Alabama.

Second, I am the former director, and now consultant, to the bureau of maternal and child health, a State agency charged with providing obstetric and pediatric care for the poor and, in a general sense, improving maternal and child health in Alabama. I would like to direct my remarks toward the provision of prenatal and delivery services for poor women and infants in Alabama and its relationship to infant mortality.

For years Alabama has had one of the highest infant mortality rates in the United States and elsewhere. An excessive number of infant deaths is linked to preventable damage such as cerebral palsy and mental retardation. All evidence shows that as we provide medical care, that every time we reduce infant mortality by three, or infant death by three, the number of children born severely handicapped is reduced by two, and there are, in addition, another five children who would have been born mildly handicapped, mildly retarded, which end normally as well. So that the process of reducing infant mortality is very clearly linked to reducing cerebral palsy and mental retardation, as well.

In Alabama, predominantly due to the provision of services for poor women and poor newborn infants, in the last 15 years we have reduced infant mortality from 31 to 14 deaths per thousand live births, and much of this reduction has occurred in the last 3 or 4 years. This means, in Alabama, 300 infants now survive each year which would not have survived only 4 years ago. In addition, this means that another 200 infants who would have been born severely damaged are now normal as well.

Nevertheless, despite the improvements to date, our estimates indicate that nearly 50 percent of the poor outcomes that we still see would be preventable by better access to medical care for poor women and infants.

While the value of saving a human life cannot be estimated, we know some of the costs to society that occur when a child which could have been born normal is mentally retarded.

Institutional care in Alabama for handicapped children now costs over $20,000 per year. This means that over the lifetime of an institutionalized child to an adult, we are talking about costs that could run up to $1 million.

We have spent considerable time determining why pregnant women and their newborns do not receive appropriate care in Alabama. Among many factors, it seems the most important is the question of funding. In Alabama, about 70 percent of all pregnant women have at least some private insurance which pays much of the cost of their prenatal and delivery care. Another 5 percent, possibly 10 percent of the women who do not have, should have private resources to pay the costs of their care.

Still another 10 to 15 percent of the pregnant women are now eligible and utilize medicaid. I should point out these are virtually all single women, and State medicaid operations do not require coverage for low-income married families. Therefore, approximately 10 percent of the pregnant women in Alabama, and these are predominantly married women, are left without any source of payment for prenatal, labor and delivery services.

Medicaid is the most substantial source of public spending for women and children in Alabama, and our estimates are it provides more than 60 percent of the public funding for infant care and maternity care. It is availability of this funding, linked with the public health system—which is predominantly supported by title funds—which has enabled us to achieve the progress I talked about earlier.

We are, therefore, especially concerned about the proposed cap on medicaid because of the likelihood that the minimal services we are now providing, services which I think have done so much good, may have to be even reduced further. Already limitations in medicaid dollars have forced cutbacks in the length of hospital stay. For example, very small newborn infants, the kind we have been talking about, which often require 2 or even 3 months in a newborn intensive care unit are now limited in Alabama to receiving only 20 days medicaid hospital assistance. That is compared, in fact, to flu, which I heard by the previous testimony was 45 days. Alabama will only support 20 days. Alabama medicaid is only 20 days.

Some hospitals are finding it, or in fact practically all hospitals find it difficult or impossible to discharge or transfer these infants once they have been admitted, and therefore there seems to be a consistent pattern developing in Alabama now that the hospitals are subtly and, in fact, now openly trying to discourage the admission of small premature babies, whether funded by medicaid or whether there are no funds at all, since medicaid again will only pay 20 days of an estimated 60 or 90 days' hospital stay.

These are very small babies often weighing only 2 or 3 pounds. We are aware this exclusion leads to a much higher death rate. Our figures would indicate much the same thing as Florida's do. We know that these babies that are excluded have higher incidences of mental retardation and handicapping conditions, and we know that while it is cost efficient to provide newborn intensive care because of the reduction of these developmental disabilities and handicapping conditions, it is not reasonable to ask hospitals to accept the care of an infant for 2 or 3 months when they know beforehand there will only be 20 days' reimbursement.

I should add that we are frequently made aware of mothers or infants whose final transportation to an appropriate hospital took longer than necessary or could not be achieved at all because of the absence of appropriate funding. The proposed cap on medicaid and the almost certain reduction in funding available for women and infants will very likely increase these incidents.

While Alabama at least today offers medicaid for prenatal care in the first pregnancy, there have been a number of attempts by the State medicaid agency, when faced with a funding crisis, to eliminate this nonmandated service.

A cap on medicaid, therefore, will virtually assure the elimination of prenatal care and possibly delivery care as well in the first pregnancy for medicaid-eligible women.

From my personal experiences as an obstetrician practicing in Alabama, I can cite numerous examples in which women in labor were turned away from hospitals. On at least six occasions in the last 2 years I have personally seen women start labor, et cetera, in north Alabama or in Tennessee, who worked their way down I-65, stopping at various hospitals, trying to get admitted, finally ending up at University Hospital in Birmingham, which at least today has maintained an open admission. They, by the way, are reconsidering that right at the moment.

In another example within the last year, a woman 7 months pregnant with two previous stillbirths——

Mr. GORE. Let me interrupt you there. You said that you personally, on six occasions in the last 2 years, have seen women working their way down the interstate from Tennessee to Alabama?

Dr. GOLDENBERG. Either north Alabama or Tennessee.

Mr. GORE. Being denied admission by five or six hospitals on the way?

Dr. GOLDENBERG. While they were in labor.

Mr. GORE. While they were in labor?

Dr. GOLDENBERG. Yes, sir.

Mr. GORE. All right. Go ahead. Excuse me.

Dr. GOLDENBERG. Another point I was starting to bring up, within the last year a woman 7 months pregnant, with two previous stillbirths and a blood pressure so high as to be immediately life threatening from stroke, was denied admission to at least two hospitals in Montgomery, because she had no money to pay her hospital bill. This was a married woman, not medicaid eligible.

A similar case 3 years ago resulted in an unattended birth which I now know that child is in an institution because of severe damage probably suffered at the time of birth.

While relatively rare, now, cases like these were common prior to the availability of medicaid funding. Reduced medicaid funding for prenatal and delivery care would enhance the possibility of their increased frequency.

In summary, the progress we have made in maternal and child health in Alabama in the last 10 years, I believe that has been dramatic. Our estimates indicate that for every dollar spent on the prevention of infant mortality and handicapping conditions through medicaid, the State will save between $5 and $10 in long-term institutional care for the severely retarded. Providing and funding of appropriate prenatal and delivery care is, therefore, not only humane, but I believe cost effective as well. I believe it is the most important action that we can take to turn the excessive number of infants born who die or are damaged, into living productive citizens.

Thank you.

[Dr. Goldenberg's prepared statement follows:]

TESTIMONY OF DR. ROBERT GOLDENBERG BEFORE THE JOINT SUBCOMMITTEES ON OVERSIGHT AND INVESTIGATION AND HEALTH AND THE ENVIRONMENT OF THE COMMITTEE ON ENERGY AND COMMERCE OF THE HOUSE OF REPRESENTATIVES

REGARDING INFANT MORTALITY

July 27, 1981

I come before you today in two capacities. First, I am an obstetrician and work providing prenatal care and delivery services, mostly to poor women in a major medical center in Alabama. Second, I am the former Director, and now Consultant, to the Bureau of Maternal and Child Health, a state agency charged with providing obstetric and pediatric care for the poor and, in a general sense, improving maternal and child health in Alabama. I would like to direct my remarks toward the provision of prenatal and delivery services for poor women and infants in Alabama and its relationship to infant mortality.

For years Alabama has had infant death rates among the worst in the country. As elsewhere, an excessive number of infant deaths is associated with excessive, often preventable damage such as mental retardation and cerebral palsy in the surviving children. All evidence shows that as we provide medical care and reduce infant mortality, the incidence of handicapping conditions is also reduced. In fact, our best estimates show that every time we reduce infant deaths by three, another two infants who, in the past, would have been so severely handicapped so as to require institutional care, will turn out normal as well. Another five who would have been less severely handicapped and/or retarded, will also be normal. Reduction of infant mortality and the production of healthy, normal babies, therefore, goes hand in hand.

Poverty, inadequate nutrition, lack of transportation and low educational levels all contribute to babies dying and children born who do not achieve their full potential. Babies of poor women, for example, have twice the infant mortality and handicapping conditions than do the children of more well to do women.

Despite the many etiologies of infant mortality and handicapping conditions, up to 50% of these poor outcomes could be prevented by providing appropriate prenatal and delivery care to all women and children, care we now know how to provide. We have had success in improving pregnancy outcome in Alabama simply by doing this. By the initiation of programs for poor women and their newborn infants, in the last 15 years we have reduced infant mortality from 31 to 14 per 1,000 live births, with much of this reduction occurring over the last 3 or 4 years.

This means that more than 300 infants now survive each year which would not have survived only 4 years ago. In addition, this means that another 200 infants who would have been born severely damaged, often requiring institutional care, now are born normal as well. Therefore, while one approach to the reduction of infant mortality and handicapping conditions suggests a broad change in social conditions, I believe we have shown that the provision of adequate medical services to pregnant women and their infants will achieve substantial improvements in pregnancy outcome and reduce infant mortality.

While the value of saving a human life cannot be estimated, we know some of the cost to society that occurs when a child who could have been normal ends up severely handicapped. In Alabama, institutional care costs the state at least $20,000 per year. A lifetime of institutional care for one child could, therefore, cost the state more than $1,000,000. Special education and treatment costs for those children born less severely handicapped are also substantial.

We have spent considerable time and energy determining why pregnant women and their newborns do not receive appropriate care in Alabama. Among the many factors, most important is the question of funding. In Alabama, about 70% of all pregnant women have at least some private insurance which pays the cost of much of their prenatal and delivery care. Another 5-10% who do not have insurance have sufficient private resources to pay the necessary costs. Still another 10-15% of the pregnant women are now eligible and utilize Medicaid. I should point out that these are virtually all single women since state Medicaid options do not require coverage for low income married families. Therefore, approximately 10% of the pregnant women in Alabama are left without any source of payment for prenatal, labor and delivery services. These women are predominantly married, often responsible people who usually pay their bills. However, they cannot afford the nearly $2,000 it now costs to receive appropriate prenatal care and delivery services. Some are refused services. Others, even if not actually refused, often choose not to seek preventive medical services rather than incur debts, which for them would be overwhelming.

Over the last 10 years, however, using the resources available to us, from Title V of the Social Security Act, state funds and especially Medicaid, we have been successful in building a program for poor women and their newborn infants which has provided access to at least some medical care for the vast majority of poor pregnant women and many of the infants. For example, in the last year, only 400 Alabama women, out of nearly 60,000 who had babies, could not find entrance to some hospital for delivery care.

Without doubt, Medicaid is the most substantial source of public funding for women and children in Alabama, providing more than 70% of all public funding for health care for women and children. It is the availability of this funding linked with a maternal and child public health system predominantly supported by Title V funds which has enabled us to achieve the substantial progress that I talked about earlier. While the system is still far from perfect, and there are many gaps in services to poor women and children, this system is working. We are, therefore, especially concerned about the proposed cap on Medicaid because of the likelihood that the minimal services we are providing in Alabama to pregnant women and their infants, may have to be reduced even further.

Already, limitations in the availability of state and matching federal Medicaid dollars have forced cutbacks in the length of hospital stay covered by Medicaid. For example, very small newborn infants which often require two or even three months in a newborn intensive care unit are now limited to receiving only 20 days Medicaid hospital assistance. Since hospitals find it virtually impossible to discharge or transfer these infants when Medicaid funding runs out, and since they are often not prepared to absorb the losses involved, some of the relatively few hospitals in the state capable of providing this highly specialized care are already subtly discouraging admission for indigent mothers and/or their critically ill newborns.

For these very small babies, often weighing 2 or 3 pounds and sometimes less, we are well aware that this exclusion leads to a much higher death rate and, even worse, a much higher incidence of developmental abnormalities including mental retardation and cerebral palsy. While we know that it is cost efficient to provide newborn intensive care because of the reduction of developmental disabilities and handicapping conditions, it is simply not reasonable to ask hospitals to accept the care of an infant for 2 or 3 months when they know beforehand there will only be 20 days reimbursement. Certain hospitals have already threatened further reduction or elimination of these services to indigents if funds are not made available.

It is relatively easy to cite specific examples of babies who could not be transferred to a hospital to receive life-saving, highly specialized care. We are consistently made aware of mothers or infants whose final transportation to an appropriate hospital took longer than necessary or could not be achieved at all because of the absence of appropriate funding. The proposed cap on Medicaid and the almost certain reduction in funding available for women and infants will very likely increase these incidents.

While Alabama, at least to date, offers Medicaid for prenatal care in the first pregnancy, there have been a number of attempts by the Medicaid agency, when faced with a funding crisis, to eliminate this non-mandated service. A cap on Medicaid, therefore, will virtually assure the elimination of prenatal care and potentially delivery care in the first pregnancy.

Financial pressure continually threatens the program of needed services in other ways as well. For example, a recent ruling by the state Medicaid agency will apparently result in their not paying for full hospital costs for some Medicaid eligible women having their first babies. University Hospital in Birmingham, therefore, has threatened to turn away Medicaid eligible women in labor if they do not have sufficient funds. Since this hospital has served as a resource of last resort for pregnant women with no other source of care, this threat is especially disturbing.

Also, from my personal experience as an obstetrician practicing in Alabama, I can cite numerous examples in which women in labor were turned away from hospitals. On at least six occasions in the last two years, I have seen a woman who started her labor at home in North Alabama, who had stopped in five or six hospitals seeking admission and being refused, before she came to University Hospital in Birmingham. In another example, within the last year a woman seven months pregnant with two previous stillbirths and a blood pressure so high as to be immediately life-threatening was denied admission to several hospitals in Montgomery. Health Department personnel personally drove her to University Hospital in Birmingham over 100 miles away. A similar case, three years ago, resulting in an unattended "parking lot" birth yielded a severely damaged, now institutionalized, child now costing the state of Alabama $23,000 per year. While now relatively rare, cases like these were common prior to the availability of Medicaid funding. Reduced Medicaid funding for prenatal and delivery care will enhance the possibility of their increased frequency.

In summary, the progress that we have made in Maternal and Child health in Alabama in the last 5-10 years has been dramatic, both in relationship to the health status of our mothers and children and the potential long-term fiscal health of the state. Our estimates, substantiated in other states, indicate that for every dollar that is spent on prevention of infant mortality and handicapping conditions through Medicaid, the state will save between 5-10 dollars in long-term institutional care for the severely retarded and day-care for the mildly retarded.

Providing and funding appropriate prenatal and delivery care, therefore, is not only humane, but is also cost effective as well. It is the most important action that we can take to turn the excessive number of infants born who die or are damaged into living productive citizens.

In this time of reduced resources and the desire to limit public spending to worthwhile and cost effective programs, it is important not to take actions which will do damage and result in even more costly future remediation. I am concerned that a cap on the total Medicaid budget will result in a decreased availability of prenatal care and hospital delivery service for poor women and their newborns.

Mr. **Gore**. Thank you very much. Very powerful testimony. We certainly appreciate it.

Ms. Mendez, I read your testimony over the weekend. It is very thorough and documented to the hilt. I invite you to proceed with any or all of it, as you see fit.

TESTIMONY OF VIVIAN B. MENDEZ

Ms. **Mendez**. Good morning, my name is Vivian B. Mendez, with North Central Texas Legal Services in Dallas, Tex. On behalf of our clients and the medically needy in Texas, we wish to express our concerns of the problems of accessibility of health care services throughout this State.

The typical pattern of a denial of access to a hospital begins when a low-income person requests medical services. Even if the person is on medicaid, the hospital, which is usually in a rural town, will explain that while they accept medicaid, there are no physicians on duty or on staff who will accept medicaid. The result is to turn the person away.

I personally observed such an incident at a hospital in Tulia, Tex., in August 1980. The hospital has been modernized with Federal grants or loans under the Hill-Burton program, and at that time had an uncompensated services obligation outstanding. The refusal violates the medicaid provisions and access requirements of the Hill-Burton regulations.

A routine method of refusing health care is to require cash deposits or copayments which the indigent person does not have. For example, on December 8, 1978, at about 9 a.m., Isidro and Rachel Aguinaga took their 11-month-old child to Dr. Murphy in Dimmitt, Tex., who was at that time serving as chief of staff at Plains Memorial Hospital.

After examining the infant, Dr. Murphy informed Mr. and Mrs. Aguinaga that their child required immediate admission to the hospital. The Aguinagas proceeded to Plains Memorial Hospital, where they requested that their child be admitted to the hospital. The hospital receptionist requested a $450 deposit. They replied that they did not have $450.

The receptionist then informed the hospital administrator that the Aguinagas were seeking to admit their child. The administrator then also asked them if they had $450. When they replied they did not, he then requested $225. The Aguinagas stated that they had no money, but that they were willing to make arrangements to pay. The administrator insisted on a prior deposit of $225 and refused to admit the sick child. He stated, "Well, a lot of Mexicans come in here to get well and then they just take off and leave."

The Aguinagas were unable to locate other medical assistance, and their child died at about 3 p.m. that same day. This was taken from the complaint filed with the Department of Health and Human Services.

In March 1981, I received a telephone call from Mrs. Alvidia Garcia, informing me that she was in severe labor pains and had been denied admission to St. Paul's Hospital, where she was a patient at the maternity clinic. She further stated that the reason for denial was for failure to pay the physician's total fee. I instructed

Mrs. Garcia to go back to the hospital and inform them that since St. Paul is a Hill-Burton facility, they cannot deny her access.

Around 11 a.m. that same morning, Mrs. Garcia called again, this time from a telephone booth, stating that St. Paul's insisted on the remaining fee and would not admit her to the hospital. This time I told Mrs. Garcia to go back and call me from the hospital so that I could meet her there. I never heard from Mrs. Garcia until a week later. At that time, she informed me that she went to Parkland, the county hospital, to deliver her baby because her pains were 10 to 15 minutes apart when she had last talked with me, and she did not want to argue with St. Paul's Hospital any more.

Last, on July 30, 1979, Hector and Cindy Castillo went to High Plains Hospital in Hale Center, Tex., to inquire about the cost required for the delivery of a baby. They were informed by the hospital that a $750 deposit was required prior to the delivery. That same afternoon, Mrs. Castillo went into labor. After arriving at High Plains Hospital, she was informed that a $300 deposit was required. Mrs. Castillo then called her husband at work. Since he did not have the cash on hand, he called his attorney and asked to borrow the money. Since the attorney did not live in Hale Center, Mr. Castillo had to travel some 30 miles away.

In the meantime, Mrs. Castillo was in the hospital lobby waiting for her husband. Once he arrived at the hospital with the $300, he was told that he needed to pay the total deposit of $750. Again, since he did not have the cash available, he called his parents and relatives and was able to come up with the money late that afternoon. Throughout this ordeal, Mrs. Castillo waited, in severe labor pain, in the hospital lobby, while her husband traveled many miles to obtain the $750.

The above incidents are just a few of the many problems of accessibility to health facilities in Texas. If you wish, further documentation of other similar cases will be furnished upon request.

Another concern is that the medicaid cap would drop elderly medicaid recipients off the Texas nursing home optional program. Since Texas chose the Federal option to cover persons in nursing homes whose income did not exceed 300 percent of the supplemental security income standard payment level, they were affected immediately by budget restrictions. Texas has experienced this due to a State legislative matching cutback in 1979. Due to the decreased funding, the result of a State budgetary limit, certain previously eligible nursing home residents at the intermediate level care II were completely eliminated.

A wave of notices were issued to individuals in nursing homes, evicting them unless their level of care was sufficiently certified. The public outcry caused the Texas medicaid agency to retract the policy for existing residents of nursing homes and apply it to new applicants. This, however, was a fictitious solution.

Let me conclude by stating that medicaid cuts will kill babies. The budgetary cuts proposed for inclusion in the budget reconciliation package will wreak havoc not only for babies, but women, minorities, the handicapped, and the elderly, and create massive financial barriers for low-income residents in Texas who cannot simply afford deposits.

I thank you for giving me the opportunity to share with you the concerns of those who would be affected if medicaid funding were decreased. If you have any questions, I will try to answer them.

[The attachment to Ms. Mendez' statement follows:]

[From the Avalanche-Journal, June 28, 1981]

Saving Lives of Poor Poses Economic Riddle

(By Larry Arnold)

At what point does economics outweigh moral considerations when saving a life?

For a physician, the question, which is as old as Hippocrates, contains no economic considerations.

But what if you are a hospital administrator plagued by uncollectible debts in the millions of dollars each year, debts which threaten to bankrupt the facility?

Or, what if you are a county judge or commissioner presented the bill for the indigent family, a single bill three times the county's normal yearly budget for all indigent care?

Charley Trimble Jr. is such an administrator.

Dawson County Judge Leslie Pratt is such a judge.

And a baby born three months premature in Dawson County and transferred to Lubbock General Hospital where treatment costs exceeded $20,000 has provided the impetus for asking such unanswerable questions.

"I'm not going to be the judge as to who should live or who should die," Trimble said. "That's strictly a physician-oriented decision."

But doctors "really don't take financial considerations into account," said one Lubbock pediatrician. "The referring doctor can't worry about what it is going to cost someone."

Trimble knows what it costs and who is likely to be stuck with the bill.

Lubbock General is supported by taxes of Lubbock County residents, not those of out-of-county residents. Yet a lot of the uncollectible bills stem from out-of-county indigent transfers.

During the past two weeks, an average of nine out-of-county patients were admitted daily to Lubbock General. Trimble said probably 75 percent of those admissions had some type of insurance.

But consider that other 25 percent, which includes, for instance, the Dawson County baby.

When the baby boy was born in late May at Medical Arts Hospital in Lamesa, he weighed 3½ pounds and the attending doctor gave the infant a 50-50 chance of survival at the facility, according to Dawson County officials.

The baby's chances of living would be greatly improved, the physician decided, if it could be transferred to Lubbock General's neo-natal intensive care unit, officials said.

The proper procedures for such transfers were followed, Dawson County and Lubbock hospital officials said. Lubbock General's receiving doctor notified the administrator on call about the pending transfer. The administrator contacted Pratt about any liability the county might have.

Pratt consulted one of the commissioners. Permission was granted although Pratt said he could only spare $2,000 "and that was the straining point."

When the baby was admitted later the same day, he weighed only two pounds, 12 ounces.

Then came the complications.

After just eight days, hospital officials said the seven pages of computer printouts concerning the infant's care revealed total costs of $7,458.30.

All of the baby's blood had to be changed three times and although the blood was free, the equipment and expertise was not. Room and board for the infant was $2,600. Respiratory therapy cost $3,107. The lab bill was $640 and the pharmacy bill was $331. Radiology charges were $253.50 and intravenous fluids cost $249.50.

The infant stayed more than five weeks. By the time it ws discharged, the bill topped $20,000.

Trimble said a bill for the remaining $18,000 was presented to the teen-age mother. The 25-year-old father cannot be found, according to Dawson County officials. His reported address and his place of business proved to be false, they said, and because county tax money was used to pay a small portion of the bill, the question of the father's residency further clouds the issue.

The case also has prompted commissioners to question their indigent medical bill policy. In this instance alone, the total medical bill—payable to an out-of-county hospital—is about twice the $10,000 allotted to Dawson County's entire annual indigent budget.

And although the indigent apportionment will be increased to $12,000 in the county's new budget, the money also must go toward payment of similar cases treated at the local tax-supported Medical Arts Hospital. "Last year, our own hospital wrote off $264,000 worth of uncollectible bills," Pratt said.

Implied but not said was the feeling the $2,000 sent to Lubbock General would have been better spent at the county's own hospital—had the doctor decided to keep the baby in Lamesa.

Dawson County got off easy this time, but what if there is a next time?

"We really should set up a policy, I guess," Pratt admitted. "But since no two cases are alike, I don't know how we could."

So, Dawson County will take cases one at a time.

Meanwhile, Lubbock General's problems remain.

In spite of a concerted effort last year by the hospital administration, only a few of the surrounding counties have inked contracts spelling out what the county's liability will be in such cases. And the bills continue to mount.

Monday, the hospital board reviewed seven accounts, all likely to be charged off as uncollectible totaling $190,000.

All seven involved services of the neonatal intensive care unit, with three out-of-county cases averaging $28,333 each. Two other out-of-county babies continue to run up bills, hospital officials noted, with one already past the $75,000 mark and the other exceeding $90,000.

Lubbock General officials are proud of the excellent reputation of their neonatal facility, but they acknowledge it is that reputation which indirectly has created some of the financial problems.

As the only level-three infant intensive care unit between Albuquerque, N.M., and Dallas, it is the target for almost every premature infant with complications. Those complications involving indigent families produce high bills and last year hospital officials reserved $4.7 million for bad debts.

It's likely a similar full bad-debt amount will continue to be necessary; Trimble said he has never turned anyone away when the case involved a life-threatening situation.

"What do you do?" he mused. "You can't repossess a baby, a gull bladder, or a kidney. What do you do?"

Mr. GORE. Thank you very much. We are going to withhold questions until we hear from the last witness on this panel, Prof. Karen Davis. Prof. Karen Davis is well known to members of both subcommittees and the full committee. It has been a great pleasure to work with you in public policy for several years. We welcome you on this occasion.

TESTIMONY OF DR. KAREN DAVIS

Dr. DAVIS. Thank you, Mr. Chairman, and members of the subcommittee, for this opportunity to testify on the importance of the medicaid program. Millions of poor Americans depend upon medicaid to obtain medical care and relief from pain, suffering, disabling, and life-threatening conditions. It has brought about major changes in the last 15 years in access to health care services for the poor, and has been an important factor in improving the health of the poor.

Yet the many achievements of the medicaid program have been overshadowed by a concern with Federal, State, and local government outlays to support the program. Contrary to popular opinion, however, medicaid expenditures per beneficiary are not higher than health expenditures for the average American. Any proposal to cap medicaid expenditures cannot be achieved through elimination of waste, but will inevitably impede access to needed health care for many of the poor.

National and local area data indicate that medicaid and other Federal health programs instituted in the 1960's have had a major impact on improving access of the poor to health services and improving health status. Perhaps the most striking evidence in this regard is the dramatic reduction in death rates in the last 15 years for those causes of death that historically have been highest among the poor.

Infant mortality, one of the most easily measured indicators of the health status, hardly changed at all in the 10 years preceding passage of medicaid. In 1955, 26 infants died in the first year of life for every 1,000 babies born. In 1965, the year in which medicaid was passed, the infant mortality rate stood at 25 deaths per 1,000 live births. Following this period of remarkable stability, infant mortality rates plummeted downward with the passage of medicaid. In 1979, infant mortality rates were 13 deaths per 1,000 live births—almost half the rate in 1965.

Studies of trends in infant mortality in inner-city and rural areas have also documented the importance of Federal health programs in reducing infant mortality. In one study of southern rural health care, infant mortality dropped by 40 percent over a 4-year period following the establishment of a federally funded health center serving the poor. In another southern county, the infant mortality rate for blacks, most of whom were users of another community health center, declined by 30 percent, while the rate for mostly higher income whites actually increased.

A similar study in New York City found that total perinatal mortality was reduced 41 percent over a 4-year period in an area served by a health center. Similar results have been found in studies from southern Florida to Denver.

The importance of medical care in reducing infant mortality has been well documented. Through medicaid or other Federal health programs providing health care to the poor, more of the poor receive medical care early in pregnancy. In 1963, only 58 percent of poor women received prenatal care early in pregnancy. In 1970, this had increased to 71 percent of poor women receiving early prenatal care. Early prenatal care is essential so that conditions such as hypertension, diabetes, and iron-deficiency anemia can be diagnosed early and brought under control.

Without such intervention premature births with resultant mortality or physical and mentally handicapping conditions will occur with high frequency. Medicaid also provides the financial means to cover care in intensive neonatal care units for premature babies or babies encountering serious difficulties. Adequate medical care in the first year of life is also important to provide prompt medical attention for gastrointestinal, respiratory, or other disorders that can be life threatening for vulnerable infants, and to provide immunizations against communicable diseases.

Significant progress has also been made in reducing death rates for adults for other causes of death that historically have been much higher for the poor than the nonpoor. Maternal mortality death rates have dropped from 24.5 deaths per 100,000 live births in 1968 to 7.8 deaths per 100,000 live births in 1979. Deaths from diabetes declined 22 percent between 1965 and 1977; deaths from influenza-pneumonia dropped 40 percent; and deaths from tuberculosis dropped 73 percent.

Not all medical care intervention results in the reduction of mortality. But medical care to set broken bones, treat ear infections or urinary tract infections, immunize against communicable diseases, stabilize chronic conditions such as hypertension and diabetes, or provide early detection of cervical or breast cancer is nonetheless worthwhile, and essential to enabling the poor to enjoy life free of avoidable pain or debilitating restrictions.

The best single measure of the extent to which the poor have access to this type of medical care assistance comparable to other Americans is the utilization of physicians' services, adjusted for the incidence of illness or injury. That is, to what extent has medicaid enabled the poor to see physicians as frequently as the average American with similar health problems?

It is in this regard that the most dramatic gains by the poor have been made in the last 15 years. In 1964, the poor saw physicians an average of 3.9 times per year, while the nonpoor visited physicians an average of 4.8 times per year, despite the fact that the poor were sicker and needed more health care than the nonpoor. In 1978, this situation had been radically altered. The poor saw physicians 5.6 times per year, compared with 4.7 visits annually for the nonpoor.

When utilization of physician services is adjusted for the greater health needs of the poor, there is still some evidence that the poor as a whole lag behind other higher income persons. Econometric studies suggest that the use of physician services by the poor is 30 percent less than the nonpoor, when adjusted for the greater medical care needs of the poor.

Certain groups of the poor—those not covered by medicaid, minorities, and residents of rural areas continue to lag behind higher income individuals of comparable health status in use of physician services. But the remaining gaps in access that exist do not detract from the very considerable progress that has been made in enabling many of the poor to live healthy lives and assure that they and their children benefit from American medical know-how.

The value of the improvement in health and access to health care services brought about by medicaid, while indisputably significant, is virtually immeasurable. Medical care is an important, but not the only, contributor to improvements in health—improvements in diet through food stamps or other nutritional programs, improved standards of living, new biomedical research breakthroughs, better education and understanding of the health-system and lifestyle changes all undoubtedly contribute to the overall pattern of change.

Some rough approximation of the dimensions of the changes that have occurred in the last 15 years with the implementation of medicaid and other Federal health programs can be obtained by estimating deaths or lack of access to health care that would occur today if no progress had been made in the last 15 years.

If mortality rates in 1965 continued today, 41,000 babies born each year that now live would die. Six hundred women that now survive would die from complications of pregnancy. Altogether, 280,000 more Americans would die every year that now survive—

including 33,000 that would have died from influenza and pneumonia, diabetes, and tuberculosis in a pre-medicaid era.

The poor would receive 40 million fewer visits to physicians to obtain relief from anxiety, pain, suffering, disabling, or life-threatening conditions. Medicaid, as by far the single largest source of improved medical care for the poor, can claim a large share of this progress as its greatest achievement.

The many significant achievements of the medicaid program have been overshadowed by concern with the cost to Federal, State, and local government budgets. Frequent allegations have been made of fraud and abuse that are perceived as responsible for rising medicaid expenditures. While abuse undoubtedly occurs in medicaid, as it undoubtedly does in private health insurance, this explanation for rapidly rising costs does not withstand scrutiny. Medicaid expenditures are high in large part because of inflation in the health care system, not because of the way in which the medicaid program is operated or abuse of the system by beneficiaries or providers.

In fact, medicaid expenditures are less than total health expenditures for most Americans. In 1976, for example, medicaid expenditures for children were $190 per child, while health care expenditures for all U.S. children were $232. Medicaid expenditures for AFDC adults averaged $393 in 1976, compared with $624 in health care expenditures for all U.S. non-aged adults. Only for elderly medicaid beneficiaries, many in nursing homes, are medicaid costs much higher than for the elderly as a whole.

Nor does medicaid cover excessive numbers of people. In fact, over 60 percent of those in poverty are not covered by medicaid—either because State income eligibility levels are well below the poverty level or because certain groups of poor do not fit the categorical restrictions limiting eligibility to the elderly, disabled, and members of families with dependent children.

The real problem with rising medicaid expenditures can be traced to a renewed explosion of inflation in the health care sector. The leading source of inflation has been in the hospital sector. Hospitals' costs were increasing at an annual rate of 16 percent in 1977. Through the threat of legislative efforts to contain spiraling costs, these increases abated somewhat to annual increases of 13 percent in 1978 and 1979. But in the first half of 1980 hospital costs increased at an annual rate of 16 percent.

In the second half of 1980 hospital costs increased at an annual rate of 18 percent, and in the first quarter of 1981 hospital costs increased at an annual rate of 20 percent.

Given these increases, it is not surprising that the administration estimates medicaid expenditures will increase by 22 percent in fiscal year 1981 over 1980, and that medicare expenditures will increase by 17 percent. Genuine abatement of increases in medicaid expenditures will only come when inflation in health care costs for the system as a whole is addressed directly.

The budgetary and legislative health proposals of this administration do not directly affect rising health care costs. Instead, most of the proposals are cost-shifting proposals. They would simply shift the burden of rising expenditures away from the Federal Government onto State and local governments, those hospitals and physicians that serve the poor, and the poor, themselves.

These proposals will lead to a reduction in health care received by the poor, may well reverse some of the progress that has been made in improving the health and use of health care services of the poor, and may have some indirect effects that increase health care costs in the longrun.

The proposed cap on medicaid expenditures would shift costs to State governments. Fiscally-strapped State governments, in turn, can be expected to shift these costs on to the poor and those providers who serve the poor. If cuts come in the form of lowered eligibility levels, 2 to 3 million poor people now covered by medicaid could be removed from coverage.

Proposals to permit States to restrict patients' freedom of choice of provider not only violates one of the most precious rights of patients, but could make it extraordinarily difficult for the poor to obtain preventive and early primary care. The result could be an increase in serious illness and life-threatening conditions—taking its toll not only in human pain and suffering but in higher future health care outlays.

Other proposed changes could also have an adverse effect on health and health care costs. Budgetary reductions of 25 percent in preventive and primary care services through such programs as community health centers, maternal and child health, immunization, and other programs will also impede access to these important services.

For example, budgetary cutbacks of this magnitude could result in a reduction of 1.1 million people served by community health center programs out of 5 million currently served, and a reduction of 0.3 million migrants out of 1.1 million served by migrant health programs. These cuts could be even more severe if these programs that go directly to local government or nonprofit organizations are included in State block grants.

Cutbacks in community and migrant health center programs will have an indirect effect on medicaid expenditures. A recent study funded by the U.S. Department of Health and Human Services compared medicaid expenditures for beneficiaries using community health centers with medicaid expenditures for beneficiaries obtaining care through hospital outpatient departments, private physicians, and other sources of care.

This study, based on three urban sites, found that hospitalization rates of community health center users were 52 percent of those of other medicaid beneficiaries and that ambulatory visits by community health center users were also somewhat less than for other beneficiaries. As a result, medicaid expenditures per beneficiary were 30-percent lower for medicaid beneficiaries obtaining care through community health centers than for other medicaid beneficiaries. Cutbacks in community health center funding could result in more medicaid beneficiaries obtaining care through more costly hospital outpatient departments and other settings.

Cutbacks in preventive and primary care services, while continuing to reimburse hospitals on a cost-basis under medicare and medicaid, will cause a serious distortion in the health care system. At a time when hospital costs are increasing at an annual rate of 20 percent, cutbacks of 25 percent in programs supporting preventive and primary care will drive an enormous wedge between expenditures on these two types of services. The health system will be increasingly skewed toward high-technology, costly inpatient hospital care—while lower cost preventive and primary care is reduced.

A more desirable alternative is to address rising hospital costs directly, through altered reimbursement methods under medicare, medicaid, and private health insurance plans or through incentives for States to establish hospital cost commissions. Evidence indicates that States with mandatory hospital rate-setting commissions reduce increases in hospital costs by 3- to 6-percentage points annually below those of States without such programs. Such approaches go to the root of the problem of inflation in the health care sector, rather than attempting to shift those costs from the Federal Government to the poor or to State and local governments.

In summary, medicaid and other Federal health programs have had a major impact on health of the poor, and access of the poor to basic health care services. Millions of Americans depend on these programs to survive and to avoid disabling or painful health problems.

A cap on medicaid expenditures threatens to reverse the gains that have been made in the past in improving the health of the poor and could well result in higher future health care outlays. A genuine solution to rising medicaid expenditures must address the real underlying reason for their growth—inflation in the health care sector.

Thank you.

Mr. GORE. Thank you, Professor Davis. Excellent testimony.

I will recognize myself for 5 minutes.

Let me ask you, first of all, if you agree with our other witnesses this morning that although it is inappropriate to apply a cost-effectiveness test to neonatal intensive care, if you do so, it turns out to be cost-effective. Do you agree with that?

Dr. DAVIS. I think it is clear it will reduce infant mortality and reduce physical and mentally handicapping conditions, and if those conditions were to occur, it is very costly to provide institutional care for those kinds of children over a lifetime; so I think on that basis, both in terms of the human lives lost, as well as the handicapping conditions that occur, certainly it is cost-effective.

Mr. GORE. Dr. Goldenberg, you say that every time we reduce infant deaths by three, another two infants who would have been so severely handicapped, so as to require institutional care, will turn out to be normal.

Dr. GOLDENBERG. Our data in Alabama indicate that to be so, and there are other studies confirming that as well.

Mr. GORE. So society, as a whole, is going to save money by doing the right thing and providing intensive care to infants who need intensive care.

Dr. GOLDENBERG. Yes, sir.

Mr. GORE. Unfortunately, the way the system is now designed, the hospitals which are charged the extra money for providing the intensive care, if they do so, are not the same institutions that will be out the additional expense of caring for those infants retarded, or given cerebral palsy, or otherwise impaired, when they don't get intensive care.

So there is no feedback loop, so to speak. They can avoid the cost by denying the provision of intensive care for infants and someone else in society has to pick up the extra cost of caring for all those impaired infants who result.

Dr. **Goldenberg**. That is absolutely right.

Mr. **Gore**. Well, it seems to me when you have a situation like that, it is just a classic case for somebody in the various State legislatures or here in the Congress to put two and two together and say it equals four: "Let's solve this problem."

Now, you are personally aware of at least one infant who is severely impaired and requires constant institutional care at the current time who was unable to get intensive care following or immediately following birth, because it was born in the parking lot and couldn't get in the hospital; is that right?

Dr. **Goldenberg**. The mother was not allowed into the hospital because she did not come up with the minimum payment for hospital care, and she was turned away.

Mr. **Gore**. That is amazing. That is amazing.

Who is paying for the institutionalization of this child now?

Dr. **Goldenberg**. It is the State of Alabama, and I am sure it is supported to a large degree by Federal funds, although I do not know the ratio.

Mr. **Gore**. So the State of Alabama declined to admit this woman, and this infant, but now the State of Alabama is paying much more money to care for this infant because of the damage that was almost certainly avoidable with intensive care.

Dr. **Goldenberg**. I don't know that it is the State of Alabama. I think what we are dealing with is a very complicated system, and it is a very fragile system that gets funding from a lot of different sources, of which medicaid is one, State money is another, private insurance is another.

What I am especially concerned about is that any breakdown in the contributions by the various sources to this fragile system is going to help the system to crumble. That is my major concern.

I don't think there are any real villains. It is hard, in the case you were discussing from Florida, I don't believe the hospital boards are the villains. They have their institutions to protect, and when they see that the funds they are getting are not going to cover the cost of the care they are providing, they are looking at a threat to their whole hospital. They have to protect their hospital. I don't see it in terms of a villain.

I just think that we have, as a system, as people looking after systems, to try to make sure that the resources are there to support the system as a whole. That is mostly what I am concerned about—the potential cutback in the medicaid program—because this is one especially for poor children, one of the major pieces to this system, and if that goes, or goes in part, I am afraid that the rest of it is going to crumble, and I think that is what we are starting to see in Florida.

Mr. **Gore**. The villain is public policy that allows this to happen. The villain is public policy—that is clear.

It may be difficult, if not impossible, to find a single individual who looked at an infant in need of intensive care and with the inflection of whiplash, snidely said no, I don't give you intensive care, but society is saying that to hundreds of infants throughout this country every year.

Dr. **Goldenberg**. That is right.

Mr. **Gore**. You talk, yourself, about women in labor, and our earlier witness talked about this. We have had the statement submitted for the record to this subcommittee talking about similar cases all over the United States of women in labor being denied admission to a hospital because they don't have the money to put up for deposit.

Now, we had some earlier questions about whether it is actually conceivable that a hospital board would be coldhearted enough to deny someone admission who needed care when they didn't have the money. I mean, that happens, doesn't it?

Dr. **Goldenberg**. Yes, sir.

Mr. **Gore**. What goes through their minds?

Let's take the six cases you cite of women working their way down Interstate 65, stopping in five or six hospitals along the way before they got to the University Hospital in Birmingham. In each case they went into the hospital and said, "I am in labor; I am having a baby," and in each case the hospital said, "Do you have enough money to pay for it?" and she said no, and then they said, "Sorry, there is no room at the inn."

Dr. **Goldenberg**. That is right. I think what happens in a defensive procedure by the hospitals is that they see this like opening the floodgate—that if they start, it will eventually lead to the financial collapse of the hospital.

Mr. **Gore**. And word will get around and other people come and take advantage of the compassion that has been so injudicially evidenced.

Dr. **Goldenberg**. That is right.

Mr. **Gore**. I yield now to my colleague, Mr. Marks.

Mr. **Marks**. Thank you very much, Mr. Chairman.

Ms. Mendez, when you were speaking about the Aguinagas' child who died, you mentioned this was taken from a complaint filed by the Department of Health and Human Services. Is that right? By them or with them?

Ms. **Mendez**. With them.

Mr. **Marks**. What has developed as a result of that?

Ms. **Mendez**. I talked with Al Kaufman, who is the attorney from Dallas, Tex., and he informed me right now they are just at the deposition stage. I asked the specific question, since I wasn't directly involved with the case, but he gave me the complete case history on this, and right now they are just still at a—it hasn't been taken to trial or anything, and they are still taking depositions from people who are involved with this particular case.

Mr. **Marks**. And the purpose of that, of course, is to build a case and then take it to trial?

Ms. **Mendez**. Yes.

Mr. **Marks**. Which the Department is, in fact, doing?

Ms. **Mendez**. Yes. It was a Hill-Burton facility. It is two separate types of cases. One is for violation of community service, and the other was for damages for the child dying and not being admitted to the hospital, so Al Kaufman is the one handling the personal injury type of case, and I believe the Texas Rural Legal Aid is handling community service obligation violations.

Mr. **Marks**. These cases you talk about were decisions made by the local hospitals as a result of their own decisions, nothing that was handed down from the Federal Government?

Ms. **Mendez**. No; strictly hospital, yes.

Mr. **Marks**. Professor Davis, you note that a sharp reduction in infant deaths took place between the years 1965 and 1979. As I understand it, this occurred actually regardless of the social class. That is, the infant deaths, themselves, were reduced for all; is that not the case?

Dr. **Davis**. Unfortunately, the death information does not have social or economic class on it.

Mr. **Marks**. Let's assume it crosses all social classes.

Dr. **Davis**. We don't know the difference by social class. We do know from one survey done in 1964 that infant mortality rates are much higher among the poor; that this is a condition that higher income people have never tended to die from at the rate of the poor.

Mr. **Marks**. We assume certainly one of the reasons for that is that they have poorer health to begin with, than those in the higher economy.

Dr. **Davis**. There are a number of factors. Higher income people are more likely to get prenatal care early, which is important for preventing prematurity. They are more likely to get care in the case of a high-risk infant and more likely will have good care in the first year of life.

Mr. **Marks**. You also mention at page 14 of your statement a Department-funded study comparing the various methods of receiving care by medicaid beneficiaries. I wonder if you could identify this study and tell us whether or not you, in fact, have it available and can you make it available to us?

Dr. **Davis**. This is a study funded by the Department of Health and Human Services in the Office of the Assistant Secretary for Planning and Evaluation. The specific contract was performed by JRB Associates, and their final report filed in September of 1980 reports these results. That final report is available to the public.

Mr. **Gore**. Will you yield?

Mr. **Marks**. Sure.

Mr. **Gore**. The Office of Technology Assessment has just completed a study entitled "The Implications of Cost-Effectiveness Analyses of Medical Technology, Background Paper No. 2, Case Studies of Medical Technologies, Case Study 10, The Cost and Effectiveness of Neonatal Intensive Care," which includes a rather impressive summary of statistics comparing infant mortality incidence by race and by socioeconomic status.

I won't put this in the record because it is quite lengthy, and people can find it with the Office of Technology Assessment. It is dated this month, July 1981. I think it will be published in the next week or so. They have evidence which shows a very dramatic difference, both by socioeconomic status, by income level, and by race.

Mr. **Marks**. Thank you very much.

I have nothing further, Mr. Chairman.

Mr. GORE. Mr. Walgren?

Mr. WALGREN. I have no questions, Mr. Chairman.

Mr. GORE. Mr. Ritter?

Mr. RITTER. My question is directed to Dr. Goldenberg and Ms. Mendez.

The unfortunate incidents which you are recounting have all occurred prior to any recent policy shift within the HHS, or within the budget; is that correct?

Dr. GOLDENBERG. Yes, sir.

Mr. RITTER. In other words, there is a kind of generic problem of refusing health care that you sense exists wherever there will be poor people; is that correct?

Ms. MENDEZ. It is to my knowledge; yes.

Dr. GOLDENBERG. I think that is an ongoing problem; that the concerns will be made worse by proposed policies.

Mr. RITTER. Let me ask you this: Do you think that that problem of the refusal of health care to the poor has been substantially mitigated or moderated over the last decade and a half of medicaid funding? Do you have any substantiation that this is true?

Dr. GOLDENBERG. I think there has been a tremendous improvement over the last 10 or 15 years. If you simply look at access to hospitals by pregnant women, as you go back to 1940, fully a quarter of all pregnant women in Alabama could not get into a hospital to have their babies. That has gotten better, to the point where we are now talking about less than 1 percent of the pregnant women in Alabama now can't get into a hospital. Much of this improvement—though not all, I believe—is related to the availability of medicaid funding.

Mr. GORE. Will you yield?

Mr. RITTER. I yield.

Mr. GORE. I would like to cite at this point a report by the General Accounting Office, which is dated January 21, 1980, entitled, "Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome."

Beginning on page 110, chapter 6—"Progress in providing labor delivery and infant intensive care services" documents very impressively and thoroughly the fact there has been indeed a dramatic improvement in outcomes as a result of the programs begun. Again, I won't put this in the record, but merely cite it for the record at this point, and I thank my colleague for yielding.

Mr. RITTER. I thank the gentleman.

Do you have any awareness about the problems of the poor and their access to medical facilities as a function of the economic climate in which they live? Is it a fact that the very feature of their poverty is pushing them into a situation where they have difficulty accessing the medical facilities because they are unemployed? Do you have any feeling for the relationship between unemployment and some of these problems? Obviously, if these are poverty people, they are unemployed, and the problems are exacerbated. Isn't that correct?

Dr. GOLDENBERG. I would believe——

Mr. RITTER. There have been studies made, as a matter of fact, which link the health problems of the unemployed to their condition of unemployment. And the foreshortened lives due to heart disease, as well as major diseases, is an outgrowth of their poverty and their unemployment.

Dr. GOLDENBERG. I am sure, in part, that is true. What I am concerned about is that we are talking predominantly about infants, where they are not employed and are not employed to start with.

Mr. RITTER. But the parents and the economic condition of the parents really is defining poverty and it is that kind of income condition which maybe is putting great pressure on the numbers of poverty-stricken people or the people who can't pull out of poverty.

I would like to ask this question: Since one can link the economic situation the country faces and the economic condition of poverty-stricken people with inflation, and what inflation has done to this country, and you say the estimates—Professor Davis has said estimates that medicaid expenditures will increase by 22 percent in fiscal year 1981 over fiscal year 1980, and if you look at a 17 or so percent increase in medicaid expenditures over the past 5 years, and you look at the problems in controlling inflation, so as to help the very neediest in the society, how do you propose to somehow bring these costs at least into proportion to other rising costs in the society?

Can we take a $20 billion program and see its costs go up by a ratcheting factor of nearly 20 percent per year?

That is really what we are all wrestling with.

Looking at the situation as a whole, where can you advise us as to somehow deal better with this program so as to help keep its costs down?

Is it possible that perhaps the increased flexibility that the administration is proposing will emerge when the States have more responsibility for medicaid? Is it possible that they will help to keep the cost down?

Is it possible that there is some fraud, perhaps, that there is a vast amount of paperwork, we know that; we know the States have been screaming about the amount of administrative expense that is encompassed by this program—is there some possibility that perhaps this different kind of administrative responsibility to the States will help reduce this ratcheting of nearly 20 percent per year?

Dr. DAVIS. I think we have to understand those increases in medicaid expenditures are reflections of those kinds of increases in the health system for all patients, private patients and publicly financed.

Mr. RITTER. I think the medicaid has been somewhat higher than the average for general hospital cost increases as I see some of the data that you have in your own report.

Dr. DAVIS. The basic problem is the fact that currently hospital costs are going up at an annual rate of 20 percent. If you look at the total cost per person, you will find the costs of a medicaid child is less than the total health expenditures on an average U.S. child.

So the payments medicaid makes are not higher than what is paid for the average person through private insurance or other means.

The States, if you just turn this back to the States, I think you are going to lose an opportunity to really deal with the direct problem of inflation in the health care system because, if you just clamp down on the medicaid part these hospitals aren't going to want to take medicaid patients.

You have to deal with the totality of patients.

Mr. **Ritter**. As makers of public policy, we need to deal with the totality of medical care costs.

As I see it, in the Senate the percentage cap to the medicaid budget is some 9 percent. In the House I guess it is a 3, 2, 1 percent reduction.

In conference I think you are going to come out very, very close to the 9 percent. That is not a vast decrease.

If you take $20 billion and you take 9 percent, you are still talking about a $1.8 billion increase in the program and, to listen to some of the testimony it is as if the floor is about to fall out.

I guess that is not the case. I think the real problem is, how do you generate a medical delivery system that is not growing by 15 to 20 percent per year, so that medicaid doesn't grow by the higher end of that spectrum.

Mr. **Gore**. The gentleman's time has expired.

Mr. Leland?

Mr. **Leland**. Mr. Chairman, I am particularly concerned, and I am really excited about the testimony that all three of you have given.

About the statements I have heard recently from my colleague in terms of the philosophy, it seems he is trying to impart about fiscal responsibility to the taxpayers as opposed to the approach of helping to save lives and helping to enhance the quality of life for those children particularly who we address here today, who seem to not have much of an opportunity to survive, in the name of fighting inflation, and what I would like to just generally ask the three of you is, do you really feel that it is more important for us to save the taxpayers money at this point in the name of fighting inflation at the expense of the lives and health of the children of our Nation?

Dr. **Goldenberg**. If nobody else is rushing to answer that question, I don't think the two are mutually exclusive.

I think we really have to pay attention to the problems we are here addressing about, you know, especially premature babies, but at the same time I would agree very much with Professor Davis that the whole system needs to be looked at so that the costs don't get so far out of control and the whole structure just tumbles down.

I think the two have to go hand in hand.

My purpose here today is really to let you know that there are specific problems with specific women and babies not getting care and in terms of how this whole picture is structured, I would hope that remains a predominant consideration.

Dr. **Davis**. I don't think you should delude yourself into thinking you are just slowing down an increase and that no one will be hurt by this because, with inflation at the rate it is going in the health sector, fewer and fewer people will be covered with these kinds of medicaid caps and reductions in funding for programs like community health centers.

It is not just a theoretical issue. There are millions of lives at stake and these people have no alternatives.

A lot of the desperate situations we have seen here concern people not even covered by medicaid or if medicaid covers them, there are restrictions in the States on the number of hospital days, meaning the hospitals won't take them.

Under the medicaid cap proposed by the administration, possibly 2 to 3 million Americans now covered by medicaid won't be covered; it will be a burden on public hospitals. They are going to react in the way some of these hospitals have by putting more and more restrictions on who will be covered and lives are very much at stake in the context we are talking about here.

Mr. LELAND. Possibly thousands and thousands of lives, if not millions of lives.

Dr. DAVIS. That is right.

Mr. LELAND. That is absolutely incredible.

As a matter of fact, Dr. Davis, if I may ask, isn't it true that we probably need more public funds for the facilitation of opportunities for more people to have access to health care services?

Dr. DAVIS. That is right, Mr. Leland.

You mentioned earlier the child health assurance plan that would have expanded the medicaid program to cover all low-income pregnant women and infants. One of the reasons these hospitals don't want a lot of these people, or require preadmission deposits, is that 60 percent of the poor are not covered by medicaid.

Two-parent families don't tend to get covered. In States like Texas, where the income eligibility level is well below the poverty level, you find many poor people aren't covered by medicaid. Up to 60 percent.

So, having some basic coverage as the CHAP bill would have done to cover all pregnant women and the children is very much needed.

Mr. LELAND. And we are not just talking about people who are not working; we are talking about possibly thousands of people who are working poor people, is that right?

Dr. DAVIS. That is correct.

Mr. LELAND. Speaking of Texas, let me just now move on to Ms. Mendez. I am particularly concerned about Texas because I represent Texas to some extent on this joint committee, and particularly I represent an urban community in Houston that is affluent because of the wealth that is gained by oil and gas.

I have made this statement many times in this context and that is that I represent more corporate oil headquarters than anybody in the U.S. Congress, but yet in some of the census tracts of my district the infant mortality rate is twice that of the white community and is comparable to the underdeveloped nations of the world.

It doesn't make much sense to me, it seems, that we are now talking about putting caps on medicaid and seizing the opportunities to gain access to health care delivery systems around this country because we believe that we have to whip inflation at the expense of lives of people in my district.

Of course, you come from Dallas and you have basically the same kind of dubious interests. You have an affluent community, a thriving city in the Nation. Houston is often referred to by the way as the Golden Buckle on the Sun Belt. And yet all these hypocrisies exist, all these conditions exist, and those policymakers that—several of my colleagues who come from Texas offer policies in this Congress that are contradictory to the interests of the lives of people in my district and the people of Dallas, because they see such great affluence and they see such great opportunity in Texas that they are blinded by our own communities.

Can you tell me of any examples that might occur through your experiences in Dallas that contradict the fact that the affluency of Dallas or Houston or Texas does not indeed take care of the interests, the health interests of the people of your community and my community, particularly from the standpoint that the affordability, once medicaid is examined, and once people are cut from medicaid rolls and, as a matter of fact, since we are not accommodating those people, those poor people of our State, with the enhancement of what medicaid has to offer, the availability of health services, or the accessibility of health services, can you tell me of examples that you see that have those contradictions?

Ms. MENDEZ. Prior to working with Dallas Legal Services, I was working with West Texas Legal Services in Fort Worth. When I was working there I had seven complainants who filed with the Department of HHS concerning—there were seven complainants. I have their names.

It was with the county hospital. We had Sebastian Lopez, we had Carol Motes, Theresa Foster, Bonnie Casas, Ruben Barrera, Sheddrick Little and Olivia Byrd who were denied to the county hospital, which was a Hill-Burton facility.

Three of these women were requiring preadmission requirements. One lady couldn't take her baby home until the deposit was made.

We tried to work with the administrator. I personally visited with the administrator and informed him about Hill-Burton. These women were not eligible for medicaid.

In Texas the only way you can be eligible for medicaid is to be on AFDC, or SSI. They were therefore not eligible.

Mr. LELAND. What is the AFDC grant, by the way?

Ms. MENDEZ. What is the amount?

Mr. LELAND. Yes.

Ms. MENDEZ. I believe it is $28 per child in Texas. We are one of the lowest in the State as far as how much we allocate to children.

I believe last year we tried to, and I think they gave us a small increase in AFDC but very little. I believe in 1969 all the way up to 1979 or 1980 there was never an increase in AFDC benefit levels, but there is an honest problem even in Fort Worth about accessibility.

At one time the hospital was requiring citizenship before they could be given services.

In west Texas, when I worked there last summer, I went to one particular hospital in Lubbock, Tex., where "if you have no income, we give you no services."

It is a pretty obvious problem that there are problems of accessibility.

More so with Mexican Americans. That seems to be in the rural towns. I have been working with people in the Plainview Health Center discussing the problems and one of the problems is the preadmission deposit. They have to have a deposit before they can deliver the baby.

Mr. **Leland**. It is incredible.

The current administration says they are going to whip inflation by cutting all these funds and at the same time they are saying we are going to depend on the private sector and the State and local governments to take up where the Federal Government leaves off.

Do you think the Texas Legislature is going to be any more compassionate?

Ms. **Mendez**. I don't think so. We have too many physicians who will not accept medicaid.

I had a Mexican American woman 2 weeks ago who had not seen a doctor for 2 years. She called me to tell me the doctor was charging her $590 because it was what medicaid had not paid and he was charging her the difference. I believe his office visits were $35 a visit and medicaid was paying $25 so he accumulated that $10 difference and came up with a total of $590 and he was charging her for that amount.

So you see even some type of fraud among physicians whose patients are not aware of the medicaid coverage or provisions are being charged in excess of what they are supposed to be paying.

That is the main problem I believe in your rural towns where physicians are not accepting medicaid. One I visited last year, the head nurse informed me he had posted notices about the Hill-Burton obligation, but she informed me there was no way they could force the physician to accept medicaid recipients.

Therefore, they referred them to another county. She says, "We can't force them to accept medicaid. Therefore, we can't accept them into this hospital."

Mr. **Leland**. My colleague from Pennsylvania earlier stated that there was a direct relationship between infant mortality and the complications of ill health and others might want to respond to that also.

There is an interdependence, or an interrelationship between poverty and the complications of ill health.

Do you think that it is the purpose of people to be poor, particularly from the Chicano community and the black community? Do you think that they have tried to be poor in order that they could gain the services that medicaid would offer? Or is it a fact that medicaid, if it is to be the kind of program it should be, it is to provide accessibility to people who cannot afford to pay for the services or who, for some reason or other, have been caught in the poverty cycle and can't get out because of the sociological complications that have been created in the black and Hispanic community in particular, or the poor white community.

Mr. **Gore**. The gentleman's time has expired.

The witness can respond.

Ms. **Mendez**. Most of these clients that I have served are low-income people. They are working people. They are farmers making maybe $400 a month. They are willing to pay; they are willing to make some kind of arrangements for the hospital costs, but the hospital just refuses to accept any kind of payments. They want an admission deposit at that point or there will be no service at all.

Mr. **Walgren**. Mr. Chairman, I did not take time in the previous questioning. Perhaps I could yield some time to Mr. Leland.

Mr. **Gore**. The gentleman has already consumed a little more than his time already.

Mr. **Walgren**. Then I have just two followup questions.

Mr. **Gore**. The gentleman is recognized for 7 minutes.

Mr. **Walgren**. I yield to the gentleman from Texas.

Mr. **Leland**. Ms. Mendez, who do you work for, again?

Ms. **Mendez**. We were formerly Dallas Legal Services. Now we are North Central Texas Legal Services.

Mr. **Leland**. Are you aware of the fact that the President might veto the bill dealing with legal services?

Ms. **Mendez**. Yes.

Mr. **Leland**. Are you here at their expense?

Ms. **Mendez**. Legal Services?

Mr. **Leland**. Yes.

Ms. **Mendez**. Yes, on behalf of our clients. Yes.

Mr. **Leland**. You have provided an invaluable service to us, coming before us to give us the kind of testimony you have. I certainly appreciate it and I hope you will serve as an example as to why legal services should be extended.

Ms. **Mendez**. Thank you.

Mr. **Walgren**. You are here as a witness, not as a lobbyist, as I understand it?

Ms. **Mendez**. Yes, that is correct.

Mr. **Walgren**. There was some conversation during the legal service approval where there were complaints about legal service attorneys lobbying on behalf of their clients for a change, and the Congress did not look highly on that, but your appearance as a witness is distinctly different from an effort to lobby.

I think that should be underscored as such for our colleagues.

Mr. **Gore**. Yield?

Mr. **Walgren**. Happy to.

Mr. **Gore**. We invited this witness and the reason we did, we looked around the country for people who were representing poor Americans who had experienced the specific kind of problems that we are looking at and we found in many cases the only people representing them were legal services, and we found this witness in Texas and asked her to come and testify.

Ms. **Mendez**. If we had the funding to bring the clients, I guarantee you would have had the clients and you would have been able to hear their testimony on where they were denied services from these hospitals.

Mr. **Gore**. We may yet hear from some of your clients and some of the other victims of this public policy fiasco in further hearings.

As one member of the subcommittee represented here, I intend to pursue this issue. I think it is something absolutely intolerable. We cannot allow it to continue and I think it deserves more attention.

At this point I would like to put a statement in from the national health law program by Geraldine Dallek.

Without objection, we will put that in the record at this point because it relates to the work that legal services has done here.

[Testimony resumes on p. 73.]

[The statement referred to follows:]

Maternity Health Care in America: Sliding Back Down the Mountain

by

Geraldine Dallek
Health Policy Analyst
National Health Law Program

We have come a long way in improving maternal and child health in America. Medicaid and other health programs for the poor have increased access to pregnancy care and significantly reduced the number of poor women dying at birth and perinatal illness and death. Yet, we have not come far enough. Too many poor women still receive late or no prenatal care, suffer high rates of involuntary miscarriage, and give birth only to see their newborns die. Increasing numbers of poor pregnant women are denied Medicaid coverage. And even those with coverage find there are no doctors to care for them or hospitals in which to deliver their babies.

We are halfway up a mountain whose summit is a system which provides every woman in America pregnancy care and every newborn an equal chance to be "well born." But, the proposed Medicaid cap and drastic cuts in maternal and child health programs for the poor signal a lack of will to go any higher. Indeed, these proposed cuts will cause us to slide back down the mountain. For the poor, that slide will mean increased maternal and infant morbidity and mortality; for the rest of the nation, that slide will symbolize our shame, for we have cared too little.

Maternal Care for the Poor: The Statistics

We can take pride in our efforts to ensure that all women in this country receive pregnancy care and all babies are given an equal chance at life. Between 1970 and 1978, the infant mortality rate dropped by 32% and the maternal mortality by 54%.[1] Our funding of Medicaid, maternal and child health programs and community and migrant health centers have made a difference to hundreds of thousands of poor women and children throughout this land.

Our efforts, however, have not been enough. The gap between white and black infant mortality rates has actually increased over the past 27 years. Black infants are nearly twice as likely to die before their first birthday as white infants. The death rate in 1977 for black infants (23.6 per 1,000 live births) was nearly double that for white infants (12.3 per 1,000 live births) and about the same as that for white infants twenty-five years ago.[2]

The inability of this nation to address the issue of newborn minority deaths is nowhere more evident than in our nation's capital. D.C. General is that city's poor people's hospital. Located in Southwest Washington, D.C. General is the primary provider of care for poor blacks living in Wards 7 and 8, east of the Anacostia River. Fully three-quarters of the women delivering their babies at D.C. General have high-risk pregnancies. The hospital's infant death rate during 1977 and 1978 far exceeded (in one instance tripled) that of any other D.C. hospital; in these three years, one-quarter of the city's newborn babies who died had been born at D.C. General--almost all were black.[3]

Babies born in the poor, black part of Oakland, California die at a rate six times that of babies born in a wealthy part of the city,[4] and involuntary miscarriages among black women in North Philadelphia are 800% higher than the national average.[5]

Washington, D.C., Oakland, California and Philadelphia, Pennsylvania are not aberrations--in every part of this nation, black newborns die at a rate far exceeding that of white newborns.[6]

Nor are blacks the only poor minority in America to suffer from high infant mortality rates. Nearly one in every two hundred births in the United States occurs at Women's Hospital, a part of the Los Angeles County public hospital system. Eighty-five percent of the babies delivered at the hospital are Hispanic. In 1978, the perinatal mortality rate at the hospital was 25/1,000 live births, nearly double the perinatal mortality rate for the state of California (14.2/1,000).[7] Indeed, statewide, the infant mortality rate among the Hispanic population is higher than that of the population as a whole.[8]

The infant mortality rate among the migrant population in this country is 25% higher than the national rate. One study of migrant workers in Wisconsin found that of the 145 women surveyed, 35 or 15% had experienced one or more children dying after birth.[9]

The link between early prenatal care and birth outcome has been well established. Prenatal care is essential to prevent many of the complications that may arise during pregnancy. Concomitantly, lack of prenatal care increases the risk of infant morbidity, mortality and mental retardation.[10]

Prematurity is associated with half of all infant deaths and increases the likelihood of birth defects. A woman who has had no prenatal care is three times more likely to give birth to a premature infant than a woman who has had that care. And, the relationship between prenatal care and infant morbidity and mortality is continuous--the more prenatal care received, the greater the likelihood of the birth of a live and healthy infant.[11]

Nationally, in 1977, 26% of all pregnant women and 40% of blacks receive no prenatal care during the first trimester of pregnancy;[12] in central Harlem, 30.3% of births are to mothers who have had no prenatal care.[13] Women in our Southern states are far more likely to receive late or no prenatal care than women in our western states with predictable results: in 1978, the neonatal mortality rate in the South was 35% higher than the rate in the western part of the country.[14]

In all parts of our country, poor women, especially minority poor women, are disproportionately more likely to receive little or no prenatal care during pregnancy and to lose their newborns through death. These statistics tell a story of neglect, but only a part of the story. They do not describe what it is like for a poor woman who is ineligible for Medicaid who cannot afford prenatal care, nor what it is like for a pregnant Medicaid recipient unable to find a doctor willing to care for her or a hospital which will admit her during labor.

Denial of Prenatal and Delivery Care

Poor pregnant women are finding it increasingly difficult to obtain prenatal and delivery care. Medicaid income eligibility standards preclude many poor pregnant women from obtaining coverage. In Texas, a family of four must have an income below $2,244 a year before it can qualify for Medicaid. It is estimated that only 25% of the poor children in Texas receive Medicaid benefits.[15] Without Medicaid coverage, poor pregnant women are often unable to obtain prenatal care and are sometimes ping-ponged between hospitals who don't want to deliver their babies.

In the three southernmost counties in Texas--Cameron, Hidalgo and Webb--few obstetricians are available to care for pregnant Hispanic women. The Lyndon B. Johnson school of public affairs estimated that in 1976, "about 50% of all children born in Brownsville (a city in south Texas) were born outside of hospitals without professional supervised prenatal, child delivery, or postnatal care."[16]

Throughout Texas the problem is the same--poor women who do not qualify for Medicaid unable to find a hospital to deliver their babies. In March, 1979, in her seventh month of pregnancy, Ernestine Valdez died of a ruptured uterus after she had been denied care by two hospitals in San Patricio County, Texas.[17] A hospital in South Fort Worth, Texas turned away at least three women in need of prenatal care because they were unable to pay pre-admission deposits ranging from $25-400.[18] At Wadley Hospital in Texarkana, a laboring woman was turned away for lack of money. The woman suffered a miscarriage upon reaching a second hospital.[19] Some hospitals in Texas are more "humane" than others. St. Elizabeth's Hospital in Beaumont refused admission to several women in labor during 1980 but did give them bus tickets to Galveston, 60-70 miles away. One of the women turned away had an income of $160 per month but was asked for a deposit of $1,700--$220 less than her yearly income.[20]

Alabama limits Medicaid coverage for a family of four to incomes below $2,880 a year. On April 7, 1981 the former director of the Alabama Bureau of Maternal and Child Health wrote that the turning away of poor women from hospitals in Alabama was not uncommon. "I can cite numerous examples in which women were turned away from hospitals. On at least six occasions in the last two years, I have seen a woman who started her labor at home in North Alabama and who had stopped in five or six hospitals trying to seek admission before she came to University Hospital in Birmingham. In another example within the last year, a woman seven months pregnant with two previous stillbirths and a blood pressure so high as to be immediately life-threatening was denied admission to the hospitals in Montgomery. Health Department personnel personally drove her to University Hospital in Birmingham over one hundred miles away. In addition, I receive numerous reports throughout the year of similar situations which occur throughout the state."[21]

Even when pregnant women can meet income eligibility requirements, they may not qualify for Medicaid: nineteen states do not cover first time pregnant women; twenty do not cover families where the father is unemployed; many states will not cover migrant families.[22] In addition, state Medicaid limitations on the number of physician and outpatient services and co-payment requirements reduce access of pregnant Medicaid women to care.[23]

Despite these limitations, however, a Medicaid card has opened the door for countless women in need of pregnancy and delivery care. That door is being partially closed. Fewer and fewer obstetricians will care for Medicaid recipients and greater numbers of hospitals, claiming they have no Medicaid accepting physicians on staff or requiring large pre-admission deposits, refuse admittance to Medicaid women in labor.

Pregnant women with Medicaid coverage often search in vain for physicians willing to accept them. Speakers appearing before recent statewide hearings in California on perinatal health care for the poor described the unwillingness of obstetricians to care for Medi-Cal recipients throughout the state: in Kern County, California, only three of the county's twenty-three OB-GYN's see new Medi-Cal patients;[24] in three California counties, none of the practicing OB-GYN's will care for this population.[25]

On July 4, 1981 a pregnant woman was accidentally shot in the arm as she watched a fireworks display in San Jose, California. She was taken to the nearest hospital but was told she would have to go to the county facility because the hospital could find no orthopedist willing to take the bullet out of her arm. "They said that because I was on Medi-Cal, they couldn't find a surgeon that would treat me." The medical director of the area's PSRO noted in response to this refusal, "Doctors' rejection of Medi-Cal or Medicaid recipients is not uncommon."[26]

For the most part, pregnant women with Medicaid coverage know not to seek care at certain hospitals. But, in several documented instances, laboring women have sought care only to be turned away. In Gilroy, California, on November 22, 1979 a laboring woman denied care at one hospital gave birth enroute to a county facility. When her baby boy was born it did not breathe and was resuscitated but died shortly after reaching the county hospital.[27]

In Fayetteville, Tennessee, a woman in advanced stages of labor was denied care by a local hospital after her family called every physician in town asking them to admit her.[28] Similarly, in Jacksonville, Florida in May of 1980 a pregnant woman was unable to find one physician on the staff of a prominent hospital in the area who would agree to deliver her baby and accept Medicaid as payment for services.[29]

In September 1977, an Avondal, Louisiana black woman in labor sought to gain admittance to West Jefferson Hospital to have her baby. She had a letter of credit from Aetna Insurance Company in addition to her Medicaid card. The hospital refused her admittance without a pre-admission deposit, which took her family a day to raise.[30]

Two months earlier, a black woman in great pain from an ectopic pregnancy was refused admittance by two Memphis, Tennessee hospitals because she was on Medicaid.[31]

Some will claim that these documented examples of inhumanity are isolated instances of a basically humane system. If only this were true. For every documented case of a woman denied prenatal and delivery care, there are hundreds more which are not documented. Some will claim that the country is aware of the problem and is doing everything it can to find a solution. This is dangerous, wishful thinking. The problem is getting worse, not better--more and more women are being denied prenatal care and admittance to a hospital when in labor. Even without the proposed Medicaid cap and massive health care cuts on the national level, state and local governments are drastically reducing services to the poor through state Medicaid reductions and the destruction of public hospitals. Our slide down the mountain is becoming an avalanche which threatens to bury our commitment to poor pregnant women and their newborns.

Medicaid Cuts and Public Hospitals

In the last year over twenty-five states have proposed or enacted drastic cuts in their Medicaid program: Kansas on July 1 dropped its General Relief population from Medicaid; Washington, Utah, North Carolina and Nebraska, among others, have proposed dropping the Medically Needy from their programs. Louisiana has adopted a twelve day limit on hospital days and Tennessee a fourteen day limit. Several states, including California and Tennessee, have proposed co-payments on emergency and primary care services for Medicaid recipients.

Other states have proposed limiting the number of emergency room, outpatient and physician visits for Medicaid recipients. Medicaid cuts will inexorably lead to a reduction in the number of childbearing age women on Medicaid rolls, additional physicians who are unwilling to care for Medicaid recipients, and hospitals which will turn laboring women away.

These cuts will also mean an increased strain on public hospitals, a major (perhaps the major) provider of obstetrical services to low-income women. In Los Angeles County, pregnant Hispanic and black indigent women refused care at private hospitals go to L.A. County-USC Medical Center, Martin Luther King Medical Center, and Harbor General Hospital. In Atlanta, Georgia, they go to Grady Memorial Hospital. In Chicago, Illinois, they go to Cook County General. In New York City, they go to the Municipal Hospital System. In Washington, D.C., they go to D.C. General.

In California, for example, poor women are increasingly dependent on county-funded services. Births at Ventura County General Hospital increased from a yearly rate of 761 in 1974 to 1,451 in 1978, "primarily due to the reluctance of private physicians to care for low-income and high-risk obstetrical patients . . ." Los Angeles County-USC Medical Center alone performs over 11,000 deliveries a year; in Los Angeles County over 10% of all deliveries are performed at this one county hospital.[32] In all, fifteen counties in California provide obstetrical services and 15% of all births in the state occur in county hospitals.[33] Without these facilities, thousands of pregnant women would be unable to obtain prenatal, delivery and post-partum care.

State Medicaid cuts and the proposed Medicaid cap will place an added burden on public hospitals and clinics, a burden which they clearly will not be able to bear. First, county and city hospitals and clinics will receive, like all health care providers, less Medicaid reimbursement. But, because they are public facilities with a legal and moral obligation to care for the poor, they will not be as readily able to turn Medicaid recipients away as will private providers. Any reductions in Medicaid reimbursement rates, eligibility or services, will thus badly hurt county hospitals and clinics.

Secondly, private hospitals and physicians, because of Medicaid cuts, will further restrict the number of Medicaid recipients they will see. Those they turn away will go to county hospitals. Four major private hospitals in Chicago, for instance, are planning to drastically reduce care for Medicaid recipients: Michael Reese Hospital is planning to close its clinic, which has served the poor for over one hundred years; Billings Hospital plans a $15 million cutback and closing of hundreds of beds currently used by Medicaid recipients; the University of Chicago Hospital plans to severely restrict Medicaid admissions by instituting a quota system; and Rush Presbyterian-St. Luke Hospital plans to eliminate specialty clinics and restrict Medicaid admissions. Where will all those Medicaid recipients go when they are refused care by the private sector? To Cook County General, which is already predicting a $24 million reduction in Medicaid money from state and federal cuts.[34] Thirdly, not only will public hospitals be asked to serve patients the private sector turns away, they will also be inundated with indigents recently taken off the Medicaid rolls.

Cities, counties and hospital districts with a legal obligation to provide health care to indigent residents of their areas are finding it increasingly difficult to do so. A dwindling municipal tax base coupled with the astronomical inflation in health care costs has resulted in public hospital closures, sales[35] and service cutbacks throughout the country. Those hospitals which are left (especially large, urban public hospitals) are in a precarious financial position.

Where will poor pregnant women go for care if there are no public hospitals left? Unfortunately, this is not a rhetorical question. A case in point is Los Angeles County. This month, the County Board of Supervisors voted by 3 to 2 to close at least eight of the County's clinics, reduce services at other clinics, and cut funding for its hospitals by 10-20%. All the county nutritionists and all but eight of the county's health educators have been terminated (two professions critical for addressing the needs of pregnant women). It is also proposed that the County refuse outpatient services to Medicaid recipients until they have tried to find those services in the private sector. The closings and cutbacks will save the county this year some $70 million in operating costs, but how much will it cost in terms of women unable to obtain pregnancy care, unattended births and maternal and perinatal morbidity and mortality? One L.A. County Medical Director, responding to a decline in the number of women seeking prenatal care due to an increase in fees at the county noted, "We really want to see those women come in. Prenatal care is probably one of our best investments." Premature babies born in county hospitals can cost the system from $10,000 to

$20,000. The lifetime care for a mentally retarded youngster can run as high as $500,000.[36]

State Medicaid cuts and reductions in locally funded indigent health care are only portents of what is to come if a Medicaid cap is enacted and if we are faced with massive reductions in all other health programs for the nation's poor.

A Medicaid Cap and Other Proposed Federal Health Reductions for the Poor

Our health care system is extremely inefficient, wasteful and inflationary. Last year alone, despite the so-called voluntary cost-containment effort, hospital costs went up almost twenty percent. To deal with this waste, inefficiency and inflation, we can do one of two things: we can rationally look at the system and the causes of inefficiency and waste and respond accordingly or we can indiscriminately cut services to those least able to protest these cuts--the poor. If the proposed Medicaid cap and other drastic federal health cuts are enacted, we will have chosen the second alternative.

A Medicaid cap will do three things: it will reduce the number of Medicaid recipients and the services they receive; it will shift costs for indigent care from the federal government to state and local governments; it will perpetuate an inequitable Medicaid system whereby indigents in some states receive far more services than indigents in other states.[37] A Medicaid cap will mean more death, disability, pain and suffering for the nation's poor.

If enacted, a Medicaid cap will accelerate the slide down the mountain. States which have proposed dropping their Medically Needy program will do so, substantially reducing the number of child-bearing poor, minority indigents eligible for the program. States which have proposed limiting emergency room, outpatient, and physician Medicaid visits to only a few a year will do so, thus denying pregnant Medicaid recipients the minimum care recommended by the American College of Obstetricians and Gynecologists.

A Medicaid cap will mean more pregnant women going to public hospitals and clinics, and a further reduction in pregnancy care services these facilities provide. A Medicaid cap will mean an increased number of poor women who will not seek prenatal care, because they know they cannot afford it and they know there are no private physicians and hospitals which will provide it.

Other proposed federal health cuts for community and migrant health centers, maternal and child health programs and health planning will also undermine the delivery of maternity care. Community and migrant health centers have proven to be cost-effective providers of services to the underserved poor. These centers provide accessible, quality pregnancy care. For example, in Lowndes County, Alabama, the infant mortality was nearly halved over four years in the area surrounding one community health center.[38] Through federal support, these centers have been established in every state of the union. A substantial reduction in the funding of these programs and a turning over of control of that funding to states will lead to an immediate decline in these centers' ability to survive.

A reduction in funding of maternal and child health programs which target services to mothers and children will result in higher maternal death rates, low birthweight babies, and infant deaths. It has been estimated that cuts in the maternal and infant care program which aids with food supplements and nutrition training for pregnant women will result in "2,000 infant deaths per year."[39]

Federal regulations and enforcement of Hill-Burton uncompensated care and community service obligations by hospitals which had received federal construction and modernization funds has meant increased access for pregnant women to private hospitals for delivery services. A decline in federal commitment to enforce these regulations will close one more access door for these women. Health planning Certificate of Need has been another forum for community groups to advocate increased hospital maternity care for the poor. A decrease in federal support for health planning and Certificate of Need will close yet another door for pregnant women seeking care in the private hospital sector.

We are not a cruel and unfeeling nation, yet the proposed cap on Medicaid and funding cuts for all federal programs which provide maternity care for the poor are cruel and unfeeling. In a civilized nation, poor women and their newborns should not be the ones to absorb massive reductions in health care.

FOOTNOTES

1. Department of Health and Human Services, Public Health Service, Better Health for Our Children: A National Strategy, The Report of the Select Panel for the Promotion of Child Health, Volume III, a Statistical Profile, 1981, PHS Publication No. 79-55071, pp. 21-22.
2. Health, United States, 1979, DHEW Pub. No. (PHS) 80-1232, p. 12.
3. Susan Okie "Keeping the Babies Alive," The Washington Post, June 18, 1980.
4. California Department of Health Services, Report to the Legislature Pursuant to House Resolution Number 70, Jan. 16, 1979, p. 92.
5. Maternity Care Coalition, Philadelphia, Pennsylvania.
6. Health, U.S. 1979, op. cit. pp. 92-93.
7. Nancy O'Donnell, Perinatal Regionalization Project, Testimony Before the L.A. County Board of Supervisors, Nov. 30, 1979.
8. Chicano Health Institute of Students, Professors and Alumni, The California Raza Health Plan, Oct. 1979, p. 34.
9. Doris Slesinger, Health Needs of Migrant Workers in Wisconsin, Dept. of Rural Sociology, University of Wisconsin-Extension, July, 1979.
10. Children's Defense Fund, Doctors and Dollars Are Not Enough, 1976, pp. 7-4.
11. National Council of Organizations for Children and Youth, America's Children 1976/A Bicentennial Assessment, 1976, p. 34.
12. Better Health Care for Our Children, Vol. III, op. cit., p. 218.
13. 27% of all pregnancies in Central Harlem resulted in negative outcomes. Letter to Secretary Patricia Harris, DHEW, from Coalition of Concerned Harlem Citizens and Organizations for Health, August 20, 1979.
14. Better Health Care for our Children, Vol. III, op. cit., p. 22.
15. Ibid, pp. 291, 293.
16. Lyndon B. Johnson School of Public Affairs, University of Texas at Austin, The Health of Mexican-Americans in South Texas, 1979, p. 131.

17. Jim Schutze, "Dead Woman's Kin Wonder Why," Dallas Times Herald, March 11, 1979.

18. Letter to the Honorable Edward R. Madigan, Subcommittee on Health and the Environment, U.S. House of Representatives from Sara Rosenbaum, Senior Health Spécialist, Children's Defense Fund, April 8, 1981. The information in the letter was taken from Hill-Burton community service complaints, on file at the Office of Civil Rights, Department of Health and Human Services.

19. Id.

20. Id.

21. Letter to the Honorable Edward Madigan, U.S. House of Representatives, from Robert L. Goldenberg, M.D., Director, Bureau of Maternal and Child Health, April 7, 1981.

22. Better Health for Our Children: A National Strategy, Vol. II, Analysis and Recommendations for Selected Federal Programs, p. 45.

23. See generally, Dallek and Parks, "Cost-Sharing Revisited: Limiting Medical Care to the Poor," Clearinghouse Review, March 1981, p. 1149.

24. California Department of Consumer Affairs, Deficiencies Cited in Hearing on Health Care for Poor Women and Infants, March, 1981. See also Koehler and De Vries, Perinatal Health Care for the Poor: A Continuing Deficiency in California, California Department of Consumer Affairs, March 16, 1981.

25. See Dallek, Health Care for California's Poor, Separate and Unequal, July 1979, pp. 40-43.

26. Elias Castillo, "Pregnant Victim Says Hospital Refused Her," San Jose Mercury, July 7, 1981.

27. Wheeler Hospital Hill-Burton complaint filed with Dr. Weinstein, Region 9 Office of HEW on January 8, 1980 by Renaldo Carboni, California Rural Legal Assistance.

28. Lincoln County Hill-Burton Administrative Complaint filed with the Office of Civil Rights, DHHS, Region IV, July 7, 1980 by Ed Steven, attorney at law.

29. Memorial Hospital Administrative Class Complaint filed with Dept. of Health and Human Resources May 27, 1980 by Ann Swerlick, Jacksonville Area Legal Aid.

30. West Jefferson General Hospital Hill-Burton and Title VI Complaint, filed with Harry P. Cain, Director, Bureau of Health Planning and Resource Development, DHEW, on February 24, 1978 by New Orleans Legal Assistance Corporation.

31. Title VI and Hill-Burton Community Services complaint filed with Harry P. Cain, Bureau of Health Planning and Resources Development, DHEW, on October 7, 1977 by Don Donati, Memphis Legal Services, 46 N. 3rd St., Memphis, TN 38103.

32. California Health Facilities Commission, California Hospital Data for Health Systems Agencies, Vol. 1 (1977), p. 24.

33. California Department of Health Services, Report to the Legislature Pursuant to House Resolution No. 70, January 16, 1979, p. 67.

34. "Michael Reese, Billings, Pres-St.Luke's to Slash Services to the Poor," Committee to Save CCH Bulletin, July 1981, p. 1.

35. A particularly alarming trend is toward the contracting out of management services or selling of public hospitals to for-profit hospital chains. The chains--Hospital Corporation of America, American Medical International, Humana and National Medical Enterprises, among others--are in business to make money, not provide indigent care. Hospital data, for example, from Georgia and Nashville, Tennessee prove that Hospital Corporation of America owned hospitals provide few services to blacks and Medicaid recipients in their communities. Data on file with Linnis Cook, Staff Attorney, Georgia Legal Services, Macon, Georgia, and Bob Ray, Legal Services of Middle Tennessee, Nashville, Tennessee. See also Dallek, "(Mis-) Management of Public Hospitals, Feeding at the Public Trough," Health Law Project Library Bulletin, March, 1981.

    Management control of Meharry Hospital in Nashville, Tennessee was turned over to Hospital Corporation of America (HCA)--a large for-profit hospital chain--a year ago. Since then numerous cases of poor blacks turned away from care have come to light. Recently, a black woman with labor pains 5 minutes apart was told to go to the county hospital as she had no Medicaid coverage. Her baby was born only minutes after her arrival at the county hospital. Phone conversation with Bob Ray, Staff Attorney, Legal Services of Middle Tennessee, Nashville, Tennessee, July 22, 1981.

36. Douglas Shuit, Medical Program Fees Under Fire, Los Angeles Times, May 21, 1980.

37. See National Health Law Program, "The Medicaid Cap: Bad Medicine for the Poor," Clearinghouse Review, Vol. 15, No. 1, May 1981.

38. Children's Defense Fund, Doctors and Dollars Are Not Enough, (Wash., D.C., 1976), p. 9.

39. American Public Health Association, Reagan Administration Policies: The Human Impacts, June, 1981.

Mr. **Walgren**. I wanted to ask whether anyone can make an estimate of whether our efforts in neonatal services, under distribution of the services, is less effective than in other countries and whether or not that is a substantial explanation of why our infant mortality rate is elevated compared to, as I understand it, Sweden or other countries that have put in place, apparently, a very good system of delivering these kinds of services.

Dr. Davis, could I ask you to answer that?

Dr. **Davis**. Yes. I think that is part of the problem. The United States is one of the few countries that does not have a national child health policy, or universal financial coverage to assure access to health care services. But certainly most of the other European countries do have specific nationwide maternal health programs that do assure all women get adequate prenatal care and that infants are cared for at birth and through early infancy.

Mr. **Walgren**. I had heard that said a number of times and it never really meant that much to me in the context of this hearing; that there is just a baldfaced evidence that our health system has failed to save certain lives that are savable in other societies because they have organized their systems differently than ours.

Mr. Ritter asked about the potential of the Reagan administration proposals to essentially give States more authority than they now have, I gather.

I can't quite figure out what the Reagan administration is up to, but the thought was it would create a block grant, reduce the funding $100 million and then allow for a market basket increase in funding year by year.

Allegedly because that would help us solve the problem of fraud and abuse by sending the administration back to the local level and it would reduce paperwork.

Now, Dr. Davis, can you make any concrete observations about the benefits or lack of benefits in sending this particular program back to the State administration? It is already State administration as far as I can figure out and for the life of me I don't understand where the savings will come from.

I wanted to specifically ask you to address the State role, the enhanced State role, the fraud and abuse and the reduction of paperwork and can you make some estimate of how burdensome is the present paperwork and what value we get from it?

Dr. **Davis**. The administrative costs in the medicaid program are reasonably low. They run only about 5 to 6 percent of the total program costs, which is lower than the administration of private health insurance policies where administrative costs run around 10 percent.

The administrative costs have not been excessively high.

The specific legislative proposal advanced by the Reagan administration would in fact enable the States to make massive changes in benefits and eligibility requirements and on selection of providers.

For example, under the legislative proposal of the Reagan administration, the States could cover only certain groups of the medically needy. They could cover just the medically needy aged and not cover any of the medically needy children.

They could choose not to cover hospital services or could choose not to cover clinic services or physician services for the medically needy. They could cover whatever services they choose. It would permit the States to impose restrictions on freedom of choice of patients to select their own providers.

They could tell patients they could only go to certain hospitals or to only certain physicians. It would eliminate the right of a patient to select their own physician or provider and be cared for by that provider which would greatly limit the access of the poor patients to get preventive and permanent care services.

It would eliminate from coverage all individuals 18 to 21 years of age, many of these in child-bearing situations, so you wouldn't pick up a lot of women during pregnancy and get adequate health care services there.

So the specific legislative provisions that are a part of medicaid—it is not just holding down spending and shifting costs to the States, but the specific legislative provisions would virtually destroy the medicaid program as it currently exists.

It would virtually remove all Federal requirements with regard to the medically needy and also many of the essential requirements with regard to welfare recipients.

Mr. GORE. The gentleman's time has expired.

I would like to thank all three of our witnesses. It is a most impressive panel. I wish we had more time to spend asking you questions. We really appreciate your testimony.

Mr. GORE. We have one final witness today. We had hoped to hear from Carolyn Davis, Administrator of the Health Care Financing Administration. There has been a miscommunication of some sort and she is unable to attend, but her assistant, Dr. Paul Willging, is with us.

Dr. Willging, you are accompanied by whom?

Dr. WILLGING. Mr. Don Muse, who is the head of the Medicaid Data Branch, Health Care Financing Administration, and on my left, Mr. William Hiscock, Acting Director of the Office of Child Health in the Health Care Financing Administration.

Mr. GORE. Your official title is what?

Dr. WILLGING. Deputy Administrator, Health Care Financing Administration.

Mr. GORE. Would the three of you please stand and raise your right hands?

Do you swear the testimony you are about to give will be the truth, the whole truth and nothing but the truth, so help you God?

Dr. WILLGING. I do.

Mr. MUSE. I do.

Mr. HISCOCK. I do.

Mr. GORE. Do you have a prepared statement, Mr. Willging?

TESTIMONY OF PAUL R. WILLGING, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DONALD N. MUSE, BRANCH CHIEF, MEDICAID PROGRAM DATA BRANCH; WILLIAM HISCOCK, ACTING DIRECTOR, OFFICE OF CHILD HEALTH; AND MARY GRACE KOVAR, SPECIAL ASSISTANT FOR DATA POLICY AND ANALYSIS, INTERVIEW AND EXAMINATION STATISTICS PROGRAM, NATIONAL CENTER FOR HEALTH STATISTICS

Dr. WILLGING. I do not have a prepared statement, Mr. Chairman. I thought it perhaps more helpful to the committee were I to respond to your specific concerns and questions regarding the administration's proposals vis-a-vis medicaid.

I would perhaps just take a minute to suggest that we obviously see the impact of the President's proposals much differently than do some of the preceding witnesses.

I think what I have heard thus far this morning has been to look at only one part of what the President is proposing.

In looking at only one part of the medicaid proposals, I think one is drawn inexorably to erroneous conclusions.

If we look only at the cap proposal and choose to ignore those other parts of the proposal basically related to changes in how States are allowed to administer the program, then by definition we are talking about cost passthroughs.

If the Federal Government pays less, nothing changes; then the states, beneficiaries and providers, must pay more.

I think if we fail to look carefully at the flexibility being proposed at the same time, we are drawn to that conclusion.

From my perspective, having worked with this program for a number of years, I think it is the flexibility that is the most intriguing aspect of what we are proposing.

The cap is to us, to some extent, an assurance that both we and the states arrive at fiscal benefit from that flexibility.

I was somewhat concerned to hear one of the previous witnesses suggest that we shouldn't give this program to the States.

My understanding in 1966, when Congress passed medicaid, was that it was designed to be a State-managed program.

We at the Federal level, both congressional and executive, have made it more and more difficult for the States to effectively and prudently manage this program.

We have begun to tell them not only who has to be served and what services are provided, but how they provide those services, who is allowed to participate as a provider and what they will be paid, to the point where States cannot prudently manage the program.

We would like to give them the authority to prudently manage the program and if they exercise that authority I do not understand why one assumes, therefore, that beneficiaries are going to ultimately bear the disastrous burden of the reductions we are talking about.

I recall your statement, Mr. Chairman, that the State legislators should be able to add 2 and 2 and get 4 when they see the cost benefits which are indubitably there in terms of child health programs.

We, on the other side, give them the flexibility to deal effectively with the much more costly elements of the program and I see no reason why they would attempt to save money at the expense of children.

Were we not to give that flexibility, we perhaps leave them few alternatives. We are proposing to give them that flexibility.

I would be happy to respond to any questions.

Mr. GORE. My statement was that State legislators and Members of Congress ought to be able to do something.

The National Center for Health Statistics in December 1980 published infant mortality rates. Without objection I would like to put into the record a table showing the infant mortality rates published by the National Center for Health Statistics. Do we have a copy for the witness? I would ask the staff to provide a copy.

[The information referred to follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date July 21, 1981

From Director, Division of Analysis
National Center for Health Statistics

Subject National Data on Infant and Child Health

To Elliot Segal
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
Through: Toni Davenport
Legislative Officer
Office of Legislation (Health)

Data on infant and child health available from the National Center for Health Statistics come primarily from four sources. The first is the vital statistics system, which provides infant and child mortality data and natality data. The natality data derive from the birth certificate which contains a number of characteristics of the mother and child including birth weight (a major indicator of subsequent mortality and morbidity). Neither of these data sources includes income or Medicaid eligibility information. The birth certificates of 47 States, however, do indicate the mother's educational attainment, which is highly correlated with income. Furthermore, 49 States report the month in which prenatal care began and 47 States report the number of prenatal visits. The attached publication summarizes natality data for 1978.

The Center is now carrying out a National Natality and Fetal Mortality Followback Survey which is designed to supplement the information on the birth certificates with mail questionnaires to the mother, the attending physician, and the hospital. These data will include a number of medical, socioeconomic, and environmental characteristics. A complete description of this survey is attached. Results will be available in late 1982.

The National Health Interview Survey (NHIS) is an annual household interview survey of the civilian noninstitutional population of the United States which includes a large number of questions on health status, health care utilization, and background socioeconomic characteristics. In 1981, the NHIS included a child health supplement which is described in more detail on the attached sheet.

Finally, the National Hospital Discharge Survey (NHDS) is a national sample of discharges from short-stay hospitals. In 1978, NHDS began to collect data on expected source of payment. In that year, 434,000 deliveries (13 percent of all deliveries) cited Medicaid as the expected principal source of payment. Deliveries to black women were much more likely to cite Medicaid than were deliveries to white women (38 percent versus 8 percent). Note that these statistics refer to expected source of payment and may differ from the actual source. Furthermore, 9 percent of the deliveries had expected source "not stated" (this percentage jumped to 18 percent for deliveries to black women).

If you have any further questions about specific data or data sources, I will be pleased to respond.

Joel C Kleinman
Joel C. Kleinman, Ph.D.

Attachment

Table 10. Infant, late fetal, and perinatal mortality rates, according to race: United States, selected years 1950-77 78

(Data are based on the national vital registration system)

Race and year	Infant mortality rate[1]				Late fetal mortality rate[2]	Perinatal mortality rate[3]
	Total	Neonatal		Post-neonatal		
		Under 28 days	Under 7 days			
Total	Number of deaths per 1,000 live births					
1950	29.2	20.5	17.8	8.7	14.9	32.5
1955	26.4	19.1	17.0	7.3	12.9	29.7
1960	26.0	18.7	16.7	7.3	12.1	28.6
1965	24.7	17.7	15.9	7.0	11.8	27.6
1970[4]	20.0	15.1	13.6	4.9	9.5	23.0
1975[4]	16.1	11.6	10.0	4.5	7.8	17.7
1976[4]	15.2	10.9	9.3	4.3	7.5	16.7
1977[4]	14.1	9.9	8.4	4.2	7.1	15.4
1978[4]	13.8	9.5	8.0	4.3	6.6	14.6
White						
1950	26.8	19.4	17.1	7.4	13.3	30.1
1955	23.6	17.7	15.9	5.9	11.6	27.3
1960	22.9	17.2	15.6	5.7	10.8	26.2
1965	21.5	16.1	14.6	5.4	10.5	25.0
1970[4]	17.8	13.8	12.5	4.0	8.6	21.1
1975[4]	14.2	10.4	9.0	3.8	7.1	16.0
1976[4]	13.3	9.7	8.2	3.6	6.9	15.1
1977[4]	12.3	8.7	7.4	3.6	6.6	13.9
1978[4]	12.0	8.4	7.0	3.6	6.0	13.0
All other[5]						
1950	44.5	27.5	22.8	16.9	24.8	47.0
1955	42.8	27.2	22.9	15.6	20.5	43.0
1960	43.2	26.9	22.9	16.4	19.2	41.8
1965	40.3	25.4	22.1	14.9	18.6	40.6
1970[4]	30.9	21.4	19.1	9.5	13.9	32.7
1975[4]	24.2	16.8	14.4	7.5	10.8	25.0
1976[4]	23.5	16.3	13.9	7.2	10.1	23.8
1977[4]	21.7	14.7	12.3	7.0	9.5	21.7
1978[4]	21.1	14.0	11.9	7.0	9.1	20.9
Black						
1950	43.9	27.8	23.0	16.1	—	—
1955	43.1	27.8	23.5	15.3	—	—
1960	44.3	27.8	23.7	16.5	—	—
1965	41.7	26.5	23.1	15.2	—	—
1970[4]	32.6	22.8	20.3	9.9	—	—
1975[4]	26.2	18.3	16.7	7.9	—	—
1976[4]	25.5	17.9	16.3	7.6	—	—
1977[4]	23.6	16.1	13.5	7.6	—	—
1978[4]	23.1	15.5	13.2	7.6	—	—

[1] Infant mortality rate is the number of deaths to infants under 1 year of age per 1,000 live births. Neonatal deaths are deaths within 28 days of birth; postneonatal deaths are deaths that occur from 28 days to 365 days after birth. Deaths within 7 days are considered early neonatal deaths.

[2] Late fetal deaths are fetal deaths of 28 weeks or more gestation. The rate is the number of late fetal deaths per 1,000 live births and late fetal deaths.

[3] Perinatal deaths are late fetal deaths plus infant deaths within 7 days of birth. The rate is the number of perinatal deaths per 1,000 live births and late fetal deaths.

[4] Excludes births and infant and late fetal deaths occurring to nonresidents of the United States.

[5] Includes black infants.

SOURCES: National Center for Health Statistics: *Vital Statistics of the United States, Vol. II, 1950-77.* Public Health Service. Washington. U.S. Government Printing Office; Data computed by the Division of Analysis from data compiled by the Division of Vital Statistics.

FILMED FROM
BEST COPY AVAILABLE

Mr. GORE. I will add for you the infant mortality rate in 1964-65 was 24.7 deaths per 1,000 and that was reduced by 1978 to 13.8 deaths per 1,000, a dramatic improvement.

Do you know what the death rate for 1980 was?

Dr. WILLGING. I am afraid I don't. That is not in my area of responsibility.

Mr. GORE. Dr. Muse, do you know?

Dr. MUSE. No.

Dr. WILLGING. That is Public Health Service data and not the Health Care Financing Administration.

I understand it is 12.9. There is a representative of the National Center for Health Statistics in the room.

Mr. GORE. We asked for a witness to represent the entire Department. So it continued to go down in 1980.

The national mortality study estimated 3.4 million live births in the year 1980. Do you have any evidence to believe that figure is inaccurate or do you accept that figure?

Dr. WILLGING. I have no evidence. Once again, I am not sure whether one asks——

Mr. GORE. We asked for a representative of the Department of Health and Human Services.

Dr. WILLGING. My undestanding is someone asked for Dr. Davis, who is the Administrator for Health Care Financing.

Mr. GORE. We asked for Secretary Schweiker and worked our way down, working courteously and at the convenience of the Department, and with the understanding that we would have someone who could speak for the Department of Health and Human Services.

Do you have anyone with you who is capable of responding?

Dr. WILLGING. I have somebody with me capable of dealing with some of the data questions.

I would remind the Chair the Department received no formal invitation, but rather a verbal invitation from staff, which was for Dr. Davis. We have not yet received——

Mr. GORE. I don't know whether you personally received a formal invitation. The Department certainly did and the record will reflect that. There should be no dispute about that.

If you can't speak for the Department, maybe we had better pursue this with someone who can speak for the Department. We specifically requested a spokesman for the Department.

Dr. WILLGING. I gather to some extent, Mr. Chairman, it depends on the questions that you would like to have responses on.

In terms of medicaid, for which I am responsible within the Health Care Finance Administration, I can deal with those questions.

With respect to activities under the purview of the Public Health Service, which I do not represent, most of them perhaps related to data, we can perhaps respond because I do have a representative of the National Center for Health Statistics here. If you are asking for policy statements with respect to nonmedicare, nonmedicaid issues, I would prefer not to speak for the Department.

Mr. GORE. Were you not advised that you were appearing here as a witness for the Department of Health and Human Services?

Dr. **Willging**. I was advised I was appearing as a witness for the Department of Health and Human Services to deal with the issues of medicaid and in particular the President's proposals——

Mr. **Gore**. Who advised you of that?

Dr. **Willging**. The staff from the Assistant Secretary for Legislation's office.

Mr. **Gore**. Who is the person who advised you.

Dr. **Willging**. Ms. Toni Davenport, who also advised me that we have not, as of this morning, received a formal invitation. That is, perhaps, why there was a mixup in communications.

Mr. **Gore**. Well, formal invitations can be conveyed verbally.

Dr. **Willging**. They unfortunately lend themselves to confusion because the first invitation which came on Tuesday suggested that it was irrelevant as to who within HCFA showed up.

As of last Friday it was indicated that only Dr. Davis was invited. I think sometimes written invitations are perhaps more appropriate so these kinds of misunderstandings don't occur in the future.

Mr. **Gore**. And Ms. Davis was unable to attend.

Mr. **Willging**. Ms. Davis, as is the case, I think, with many people on the Hill as well, is dealing with conference activities today, one of them being the medicaid cap which is currently being discussed in conference.

Mr. **Gore**. We haven't gone to the practice of subpenaing witnesses from the department because we have had, over the years, a good working relationship. Maybe we will just proceed in the best way we can today and pursue it with the appropriate people who feel they can speak for the department in a subsequent hearing. I hope there will be several hearings on this subject.

At any rate, your person from the National Center for Health Statistics doesn't have anything that would lead him or her to disagree with the estimate of 3.4 million live births in 1980; is that correct?

Could you identify yourself for the record?

Ms. **Kovar**. Mary Grace Kovar.

Mr. **Gore**. Raise your right hand.

Do you solemnly swear that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

Ms. **Kovar**. Yes.

Mr. **Gore**. You think the 3.4 million live births is a good estimate for 1980?

Ms. **Kovar**. Yes, sir, it is what the States report to us.

Mr. **Gore**. If the infant death rate for this year is the same as for 1978, there would be close to 46,000 infant deaths. If it is the same as for 1980, it would be slightly less than that, still more than 40—well, around 44,000 to 45,000 infant deaths. Is that a reasonable estimate?

Ms. **Kovar**. I haven't done the arithmetic, but it sounds about right.

Mr. **Gore**. How many of the estimated 45,000 infant deaths were medicaid recipients?

Ms. **Kovar**. I don't know.

Mr. **Gore**. Doctor, how many of the estimated 45,000 infant deaths were medicaid recipients?

Dr. **Willging**. I couldn't respond to that precisely. About one out of eight children in America are covered by medicaid. I doubt that that applies to infant deaths. We can supply that, if possible, for the record, Mr. Chairman.

Mr. **Gore**. We asked for that specifically in preparation for the hearing, from the department.

Do you have a guess, or a ballpark figure?

Dr. **Willging**. I wouldn't presume to guess, sir. I would prefer to supply that for the record, provided such data is available.

Mr. **Gore**. I am informed by staff that last Tuesday that specific question was asked, and we specifically requested for this hearing a response. I don't know why the atmosphere seems to be different.

Let me continue. We will ask for that for the record.

[The following response was received:]

We have looked into a number of sources, and there are no data available to determine the number of medicaid recipients among the infant deaths in 1980.

Mr. **Gore**. According to the National Hospital Discharge Survey, 13 percent of the deliveries expected medicaid to be the source of payment. Now, as you indicated, that would mean approximately one-eighth, or there would be approximately 6,000 medicaid deaths of infants this year, or this past year, from all causes. Obviously because of socioeconomic differences, income differences, racial differences, the figure has got to be much higher. We will look for that estimate.

Have you done a cost-benefit analysis that shows, or would show, the Federal saving from a medicaid cap and match that with the costs of increased mortality and disabling illness as a result of the cutbacks?

Dr. **Willging**. No, Mr. Chairman, because we don't accept your premise that the savings would necessarily lead to the kinds of cutbacks that would impact adversely on morbidity and mortality.

Mr. **Gore**. You don't think there will be any service cutbacks?

Dr. **Willging**. We do not think there need be service cutbacks. That is a distinction, Mr. Chairman. We think it is safe to use the flexibility we are proposing to give the States; that the ultimate detriment to the beneficiary need not occur.

If a State chooses to operate the program without making use of that flexibility, without changing its approach to the purchase of services, then there could be, in fact, those kinds of——

Mr. **Gore**. What specific increase in flexibility in the medicaid program do you estimate to produce the largest savings?

Dr. **Willging**. I think perhaps the most dramatic savings could come about by increased flexibility in the area of reimbursement to providers, particularly institutional providers, and the increased flexibility States will have to use competitive procurement practices for some of the other services, which statutes thus far have prevented them from using—for example, laboratory services.

Dr. **Gore**. Reimbursement flexibility—can you give me a specific example of what kind of thing a State will do that it can't do now that will produce enough savings to make up for the amount of money that is not provided?

Dr. WILLGING. I think what the States will be able to do is move away from a reimbursement system in the institutional setting called cost reimbursement which has been one of the more inflationary tendencies in the health delivery system.

It will mean, to give you a specific example—whether a State would choose to go that far, I am not sure—when it purchases a tonsillectomy on behalf of one of its beneficiaries, and if it can, at acceptable levels of quality and with due concern for access, purchase that tonsillectomy for $1,500 from—take a hospital I am familiar with—Howard County General Hospital, it would be allowed to do that, rather than having to pay whatever hospital the beneficiary chooses to use, be it perhaps Johns Hopkins at $3,000. There can be fairly dramatic savings if States choose that flexibility.

We had a situation some years ago where the State of New York wished to purchase laboratory services by competitively bidding for those services in the State. They were taken to court and, as a result of the statute, they could not go ahead with that kind of approach, even though they could document millions of dollars of savings for the State in using that approach.

Mr. GORE. As an analyst looking at the future, do you believe if the medicaid cap is put into effect, do you really believe that there is not going to be a cut, and a dramatic cut, in the amount of medical care made available to poor people?

Dr. WILLGING. I believe, Mr. Chairman, that there need not be——

Mr. GORE. I am asking you whether you think it is going to happen or not. Do you really believe it is not going to happen?

Dr. WILLGING. I believe that in some States, and hopefully a very limited number, there may be cutbacks in the actual services provided to the individuals. I also believe very firmly that the underlying philosophic nature of this program is that States are in as good a position as we are to determine what is best for their citizens. I do not believe we at the Federal level have a monopoly on compassion or beneficence. States should be allowed in this program, to establish a State program, to make those choices for its citizens.

The States do, after all, put in up to 50 percent of the cost of this program.

Mr. GORE. Do you really believe that in most States there will be no cut in medical care for poor people?

Dr. WILLGING. Do I believe in most States there will be no cut?

Mr. GORE. Yes?

Dr. WILLGING. I can't presume to speak for how States will use this flexibility.

Mr. GORE. What do you think will happen? Do you really believe there will not be a cut in most States?

Dr. WILLGING. I think my personal opinion is irrelevant to this, Mr. Chairman.

Mr. GORE. Well, I am asking you for it.

Dr. WILLGING. I believe in most States there will not be appreciable cuts in services to the poor.

Mr. GORE. Then I guess it gets to what the definition of appreciable is.

I don't think you really believe it. I don't think the administration really believes it at all. I think they realize what is going to happen.

Mr. **Walgren**. Mr. Chairman, it seems to me the witness has said he does believe that in some States there will be cutbacks in services.

Mr. **Gore**. Yes, he went that far. He went that far on the record. And he is in a tough spot, and I don't wish to personalize it at all; I really don't.

I just think that too often we turn our eyes away from the consequences of policies, and the consequences of this policy are going to be pretty bad for a lot of poor people, and for a lot of infants in the circumstances that baby boy, Downing, found himself in in the few hours in which he lived.

Dr. **Willging**. But let's do it with statistics, Mr. Chairman. Even the original proposal by the administration which was a 5-percent cap in 1982, then to be followed by a GNP deflator for subsequent years, would have been a reduction for State and Federal funding for the medicaid program in 1982, a reduction of only 3 percent from what the States had anticipated spending in 1982.

Now, that is not to say a reduction below what they were spending in 1981, but only 3 percent from what they, themselves, had said they were going to spend in 1982. I don't consider that a Draconian reduction in the rate of growth of the program.

What is coming out of conference is likely to be not very close to 5 percent. If there is a cap, likely it will be closer to 9 percent, which is that much smaller a reduction in the rate of growth.

The reason I can say, I think, fairly categorically that in most States there will not be a reduction in services made to the poor, we are not talking about having to absorb much. What we are talking about is providing flexibility and also closing the entitlement of this program in terms of where State access to Federal funds is concerned.

This is not, I think, what has been bandied about today in terms of dramatic Draconian reductions in the cost of the program. It simply is not that.

Mr. **Gore**. Could you provide for the record any analysis of the expected consequences State by State that you all have compiled?

Dr. **Willging**. That would lead me to try to assume for State legislatures what decisions they will make over the next year and a half.

Mr. **Gore**. In other words, there has been no sufficient analysis.

Dr. **Willging**. There could not, by definition, be such an analysis.

Mr. **Gore**. I recognize my colleague, Mr. Marks.

Mr. **Marks**. Thank you, Mr. Chairman.

Dr. Willging, Mr. Hiscock, Dr. Muse, we appreciate your coming here, particulary under the circumstances in which you find yourselves. I do appreciate the fact that you have come here to discuss issues of medicaid in particular, and that you are prepared to do that.

I would like to ask you some specific questions. Even though some of this—the answers to these questions I assume you have made to some degree already, but I think the record ought to stand on the specificness of the question that is appropriate to that which we are discussing today.

I would like to know what the current status is of funding for the maternal and child health program, and what does that funding mean for service delivery—if you can tell us, please.

Dr. **Willging**. I am afraid I must apologize—the maternal and child health program, I can't. I don't know whether Ms. Kovar can. It is not in her area, either. If there was a misunderstanding as to which would represent the Public Health Service, I apologize for that. I could get that information for the record, or, if the Chair is proposing additional hearings, we will make sure a departmental representative is there.

Mr. **Marks**. I raised the question so that you might get that information to us, if you will.

Dr. **Willging**. I will be happy to do that.

[The information follows:]

The Ominibus Budget Reconciliation Act of 1981 established a maternal and child health block grant. This new title V block grant authorizes funding of $373 million for fiscal year 1982 and each year thereafter, and includes the current programs in maternal and child health/crippled children's services, SSI payments to handicapped children, genetic diseases, adolescent pregnancy prevention, lead-based paint poisoning, hemophilia, and sudden infant death syndrome. This funding level is approximately $53 million less than appropriated for these programs this year.

Funds in this block grant may be spent only for maternal and child health services, including services for crippled children. However, the exact impact of the block grant is unclear since States may choose in which quarter during fiscal year 1982 to have the block grant take effect. Until States elect to administer the block grant, HHS will administer the programs as in the past, with funding coming from the amount appropriated from the block grant authorization.

Mr. **Marks**. If a cap is placed on the Federal reimbursement for medicaid services, are you not concerned that services available to pregnant women and infants would be reduced?

Dr. **Willging**. I am not concerned for this reason: States can indeed make these cost-benefit analyses as to what is going to save them money down the pike if they are willing to put in sufficient investment today. And I think that States have been able to make those kinds of decisions.

This is just one example: One of the reasons I feel that sanguine is, I look at an optional service we currently provide, say, in the medicaid program, and that is the States' right to cover pregnant women who are not presently categorically eligible, but would be categorically eligible for the program once that child were born. Thirty to 35 States currently provide that optional service. Even in terms of the particular fiscal crises that most States have come through over the last few months, long before the cap was proposed; generally, States have not been willing to tamper with that optional service. To some extent, that affects the degree to which they make these judgments.

I don't think, especially with the flexibility we will give them on the high dollar items, they are going to cut off their noses to spite their faces. I think they will leave those services there and concentrate on the areas where we are going to give them flexibility.

Mr. **Marks**. I have nothing further. Thank you.

Mr. **Gore**. Are you aware that in the last year 25 States have enacted or proposed drastic cuts in their medicaid programs?

Dr. WILLGING. Yes, I am. In fact, there are some 200 different cuts that have been proposed in medicaid programs across the country.

Mr. GORE. Do you expect that trend to change?

Dr. WILLGING. I expect that trend to be channeled differently once the administration's proposals for enhanced State flexibility go into place.

Mr. GORE. Now, by "channeled differently"—channeled in the direction of increases?

Dr. WILLGING. No; channeled in the direction of the way one chooses and reimburses the providers.

In the absence of flexibility States have very few areas right now where they can cut costs. We have so tied them up by both statute and regulations that when they want to cut costs, they end up by having to cut them by reducing eligibility levels, taking out certain services and what-have-you, most of which impacts adversely on the beneficiary. If we give them the flexibility to deal with what is really the problem in health care financing—it is the way we choose and reimburse providers—I would hope those changes would begin to show up in that area.

Mr. GORE. Do you think that the Federal Government ought to play a role in providing reimbursement for neonatal intensive care?

Dr. WILLGING. I couldn't express an opinion on that as to whether or not the medicaid program should do it specifically; I would think only within the current provisions of the program. That is when States make choices to provide those services to certain categories of eligibles, as long as they are shown to be efficient and efficacious, we should provide the funding through medicaid. With regard to making the choice up front to stimulate health care delivery, that is not the role of the medicaid program. Whether it should be provided elsewhere in the department, I would defer to a departmental representative who could deal with that one.

Mr. GORE. Are you aware that medicaid currently only covers one-half of the cost of neonatal intensive care, on average?

Dr. WILLGING. No; I am not aware of that, Mr. Chairman.

Mr. GORE. Well, the record will so reflect.

Dr. WILLGING. Will the record define how that computation was made and what it means by one-half?

Mr. GORE. Give me your estimate of what percentage medicaid covers, on average, of neonatal intensive care.

Dr. WILLGING. I don't know, but I think it is important to find what one means by the question. Do we mean that of the services provided across the country medicaid is paying for half of it? Do we mean that specific service in a State——

Mr. GORE. I am talking about a specific case—neonatal intensive care. When you look at a medicaid patient's child, or a child where the hospital is reimbursed by medicaid, what percentage of the cost of that care provided by the hospital is covered by medicaid, on average?

Dr. WILLGING. Well, the way States reimburse hospitals, which reimburse according to medicare principles which reimburse all medical costs, in that definition, I would find it hard to believe that only 50 percent of the costs were covered.

Mr. Gore. I am asking you what the figure is, on average. What is the figure? We have asked the department to come here and talk about neonatal intensive care, and you are walking us all the way around the barn and saying I don't know this and don't know that; not qualified to speak about this; not qualified to speak about that. You said you are qualified to speak about medicaid; you knew you were coming here as a representative of the department to talk about neonatal intensive care.

Now, I have asked you what percentage of neonatal intensive care reimbursement is provided by medicaid.

Dr. Willging. By definition, Mr. Chairman, 100 percent of the reasonable cost.

Mr. Gore. One hundred percent?

Dr. Willging. One hundred percent.

Mr. Gore. So the Department of Health and Human Services spokesman is coming here and telling us that 100 percent of the hospital's charges for neonatal intensive care are provided by medicare?

Dr. Willging. I did not use the word charges. I said of the reasonable cost of providing institutional——

Mr. Gore. Take the amount of money that the hospital has to cover. What percentage of that cost is provided by medicaid?

Dr. Willging. I can't answer that question.

Mr. Gore. Why can't you answer that question?

Dr. Willging. Because I think you are placing the question in a context which doesn't lend itself to answer. We do not reimburse all costs, or certainly charges of hospitals. We reimburse reasonable costs. I don't have available to me right now across the nation what the average difference is between hospitals' costs and reasonable cost. I am sorry, but that is the way the program is structured.

Mr. Gore. I am sorry, too. And the parents of infants around the country who have to rely on this program are sorry, too, and those who will be affected by your proposed cuts will probably be sorry that you don't have that information available before proposing the cuts.

Now, it does not seem to me to be an unreasonable question. This is a tragedy in this country, Dr. Willging. There are lots of infants denied intensive care. We have heard testimony today that hospitals are under financial pressure to cut out neonatal intensive care units because it is an expensive service.

Now, we asked for the views of the administration on this question, and for whatever reason you are unable to give us just as elementary a fact as how much of the cost is covered.

You see, if hospitals are cutting it out because they are under financial pressure, it seems to me it is reasonable to ask some questions about the financial pressure they are under.

If medicaid was providing 100 percent of the reimbursement of neonatal intensive care, then they wouldn't be cutting out these units.

If you don't know what percentage is being covered by medicaid, then how can you propose these cuts if you don't know something as elementary as that? Are you saying that somebody else in the department may know it; it is just that you don't?

Dr. WILLGING. No, I am not, Mr. Chairman. I am not saying that at all. What I am saying is that, as we have also heard today, some of the problems we are dealing with have nothing to do with medicaid. As Ms. Mendez indicated, five of the cases she indicated were not even eligible for medicaid. If that is what the hospitals are saying, that they have a bad-debt problem because not everyone is eligible for medicaid, then obviously all their costs are not covered. What I am suggesting is that as long as the question is imprecisely defined, it is difficult to provide an answer.

Mr. GORE. My question is not imprecise, Dr. Willging. I beg to differ. I have asked you a specific question. A very precise question. What percentage of the cost of neonatal intensive care is covered by medicaid when the patient is eligible for medicaid reimbursement, and you do not know the answer to that precise question, which is the subject of the hearing today.

Dr. WILLGING. I provided an answer to that specific question, Mr. Chairman.

Mr. GORE. Tell me again. Maybe I missed it.

Dr. WILLGING. The cost to a medicaid-eligible patient, or for that patient, in a hospital, the reasonable costs are covered at 100 percent——

Mr. GORE. Now wait a minute. I didn't say reasonable costs. I said what costs of the hospital.

As you know, reasonable cost is a phrase of art. It is a phrase of art, and it is subject to a lot of twists and turns by the accountants and the front office at the hospital.

I am asking you what percentage of the costs incurred by the hospital is covered by medicaid. Do you know the answer?

Dr. WILLGING. Off the top of my head, I do not know that answer. I can provide the answer.

Mr. GORE. Have you looked for the answer prior to this hearing?

Dr. WILLGING. No; I haven't looked for the answer.

Mr. GORE. Why not?

Dr. WILLGING. Because I was unaware of the question prior to this hearing.

Mr. GORE. Were you aware of what the hearing was about?

Dr. WILLGING. I was aware generally that the hearing was with respect to the President's proposal for medicaid and its impact on child health.

Mr. GORE. Did this question come up in the legislative meetings which produced the department's proposal for the medicaid cap?

Dr. WILLGING. Not in those I was in attendance at, but most of those meetings were held at levels between the Secretary and the Office of Management and Budget.

Mr. GORE. Obviously we are going to have to get another witness—other witnesses—to answer these questions.

You heard the testimony this morning. Did you follow this case in Florida that we heard this morning that was not untypical at all. Were you aware of that prior to the hearing?

Dr. WILLGING. My understanding was that the case in Florida wasn't even clear that the person was medicaid eligible.

Mr. GORE. Do you think it would be a good thing to try to work out a system that would insure that all infants who needed neonatal intensive care in this country could get it?

Dr. WILLGING. I think that is a judgment that has to be tempered by cost factors as well. I think if resources were unlimited, I think we should cover anything that seemed to be cost effective in health care delivery.

Mr. GORE. But if we don't have the resources, then we ought to deny it to some?

Dr. WILLGING. That is the inevitable nature of this system. It happens every day, not just in neonatal care. I was the chairman of a board of a hospital in Maryland. We had an emergency room which, upon occasion, had to force the ambulances to bypass it, because we didn't have another bed available. That didn't mean we should simply put in sufficient numbers of beds to take care of every eventuality. We always deal with cost questions and resources. We don't like to think we are doing that, but we do.

Mr. GORE. I don't like to think we are doing that, and I don't like to do it, and I am going to do what I can to see that we don't do it, but let me ask you the question again in a slightly different way:

Do you believe that if we don't have the resources, then we ought to deny neonatal intensive care to some infants who need it?

Dr. WILLGING. I think that is a loaded question, Mr. Chairman.

Mr. GORE. It sure is. It sure is. What is your answer to it?

Dr. WILLGING. My answer is, probably to avoid it by saying I can't think of any public policy decision that doesn't have to weigh costs, benefits, and competing demands for resources.

Mr. GORE. That's a yes?

Dr. WILLGING. It is not a yes, and it is not a no. It is a refusal to in effect come out with that sort of an analysis and say, "Yes; I am for it," or "I am against it."

Mr. GORE. Do you think we ought to have a policy in the United States that all infants who need neonatal intensive care and whose lives could probably be saved by that care, should be afforded that care?

Dr. WILLGING. I think that is the same question put differently, Mr. Chairman.

Mr. GORE. Do you think we ought to have that kind of policy or not?

Dr. WILLGING. I think we have by default a policy wherein care is rationed in this country, as it is in any country.

Mr. GORE. Do you think we ought to change that?

Dr. WILLGING. No; I think we ought to make sure it is rationed in a much more effective manner, and that is precisely what both the administration and Members of Congress are trying to do in the competitive proposals for health care financing.

Mr. GORE. Realizing that by accepting the principle of rationing neonatal intensive care, we will condemn some infants, all of them, or more of them, necessarily poor infants, to a death when they might otherwise have lived if we had a different policy?

Dr. WILLGING. No, I am saying as a result of a conscious or at least a market rationing principle, it may be precisely that area where the choice is made to put the resources.

Mr. GORE. Dr. Muse, you are in charge of maternal and child health.

Mr. MUSE. No; I am in charge of medicaid data collection.

Mr. GORE. Within HCFA?

Mr. Muse. Yes, sir.

Mr. Gore. Do you appear here as a representative from HCFA?

Mr. Muse. I am here as staff to Mr. Willging.

Mr. Gore. Mr. Walgren?

Mr. Walgren. Thank you, Mr. Chairman.

The underlying conflict I have with what you have represented here today is that, on the one hand, you say that you believe in response to the need and the problem of limited funds, that you must resort to the most effective rationing system that you can.

The problem that I have is that you then turn to the States as playing the primary role. It seems to me that in doing that, you are turning to the least competent social institution and, by competition—I don't mean able in the mental sense, but in the financial sense—the least able to pay institutions and putting the burden on them. Isn't that the effect of the administration's plan? And how does that enable you to provide services to people that you want to provide them to, but that you admit are not receiving them and that you have to ration?

Dr. Willging. I guess using your definition of the word "competent," Mr. Walgren—and I tend to agree with that definition—I would see them as the most competent—not only in the fiscal sense in that they do not have the luxury of printing presses as far as finances are concerned, but certainly I think in terms of knowing what the particular needs of a population in a given State are, the particular nature of the provider community and the array of facilities available.

I think the States are in a much better position to make those kinds of choices than the Federal Government.

It is very difficult to make even the gross choices we make with respect to medicaid and hope they can equally apply to all 54 medicaid jurisdictions.

Mr. Walgren. Let me ask you this: What would prevent the Federal Government—you have cited one instance or one suggested way forward, where money can be saved by the States, and that is to allow them to engage, through purchasing and group arrangements. What is to prevent the Federal Government under the present system from allowing such purchases to be made by States under the present system of medicaid financing?

Dr. Willging. In terms of group purchasing the example I gave being laboratories, the thing that prevents States from doing that is the statute.

Mr. Walgren. Now, why would you not recommend that we simply change that statute and allow States to engage in group purchases rather than coming in with a cap on the program which you, yourself, indicate will, if the States do not so do, result in denial of services?

Dr. Willging. I think we have done both, Mr. Walgren. We have come in with I believe about eight specific proposals for change in the statute across the board from reimbursement to group purchasing, and what have you. We have also indicated that we and the States have to look at this program as something more than simply an open-ended entitlement in terms of State rights to address the Federal Treasury.

Mr. **WALGREN**. It is true, is it not, there are tremendous incentives on the States to limit benefits as much as possible under the present system inasmuch as, up to and over a half of all the dollars paid in are shared dollars?

Dr. **WILLGING**. That is correct, but at the same time there are also incentives for simple cost shifting. That also takes place in the States, and I think that the Federal Government has the right to expect as a quid pro quo for this flexibility, that there be recognition that there is a limit of some kind on the program. I think it is a very small limit for 1982, 3 percent of anticipated expenditures.

Mr. **WALGREN**. By cost shifting, what do you mean?

Dr. **WILLGING**. There are benefits that had traditionally been a State preserve, where, in effect, the State was paying 100 percent of the costs and they have been moved into the medicaid program so as to pick up the 50 to 80 percent of Federal financing. I think there are incentives not only to save money but save it by simply maximizing Federal reimbursement. By just providing for flexibility I don't think we could get a handle on those kinds of problems.

Mr. **WALGREN**. Now, I trust that those areas of cost are eligible for Federal participation.

Dr. **WILLGING**. Sometimes they are not.

Mr. **WALGREN**. And then payment is denied, so that is no problem.

Dr. **WILLGING**. They are denied in all cases where we find them, but we will never have, nor would I ask, for the resources to check in that kind of detail all State expenditure reports every quarter. We try to hit the major ones, but I think an incentive which, in effect, is no longer an incentive would be a much more effective way of dealing with that issue. There are many things which we have to do bureaucratically to keep on top of the States in terms of their adherence to the rules which I would prefer to do through the incentive of simply having a cap. Then if States choose to maximize by having ineligible people on the rolls and providing services not actually covered under the program, then we can stop harassing the States in terms of some of the regulatory burden we put on them.

Mr. **WALGREN**. The regulatory burden was testified earlier to be less than the private paying burden and it is something in the range of 5-percent administrative cost.

Dr. **WILLGING**. It is about 6½ percent now.

Mr. **WALGREN**. What is Blue Cross and Blue Shield?

Dr. **WILLGING**. Comparing apples and oranges. I tend to disagree with Dr. Davis that you can compare medicaid administrative costs which do not include such things as marketing policies, Blue Cross——

Mr. **WALGREN**. In fact, the administrative costs are substantially less in the private sector and the private sector is willingly paying those costs in each of their policies so they would certainly not view the administrative costs in medicare as unreasonable if they are one-half of what they themselves are reasonably paying; isn't that correct?

Dr. **WILLGING**. But they are different functions, Mr. Congressman.

Mr. **Walgren.** You indicated that you felt the States could add two and two and get four, too, and if they felt there was a cost effective program, that they would not then deny, or attempt to save money on children.

However, is it not true that the real question is when the money is saved, and that our society is loaded with examples of situations where people chose to pay a lesser amount in the future but a greater amount throughout the lifetime of whatever it was they were purchasing, than situations where they paid the full amount up front and saved in the long run. Isn't that true?

The States will be in no different position. If the lifetime costs of saving this money, even though it is cost-effective, if the lifetime costs may be greater—costs greater than the initial investment, but if there is a way to get through the problem in the near term by paying out a little less than that investment, the States will probably do that, will they not?

Dr. **Willging.** I think it depends on when you are going to see those savings, Mr. Walgren. I think truly if you don't realize the impact of that investment until 6 or 7 years down the pike you are inclined to slough over this year's problems but many of those——

Mr. **Walgren.** Let's just take that statement and apply it to the neonatal problem. As I understand it, one of the problems in this area is that the children without neonatal care will be retarded.

Now, when do the costs for the care of the retarded really start to hit?

Dr. **Willging.** That would be an example of one where perhaps one would slough over that. There are others where in effect you see those returns fairly dramatically and fairly quickly——

Mr. **Walgren.** Doesn't it make sense where you identify a problem where the States—and we know the history. The history of the States is they are in tremendous financial pressure. You are turning and asking the States to make a cost-effective decision for 50-year runs, why they are cutting back Federal care in many different ways because they haven't the money to pay for it.

You are relying on that body to make that long-range decision when you, yourself, admit that there is one they will slough over, as you say.

When you can identify a situation where they will on your own admission slough over it and endure those higher costs at great cost of human suffering and loss and the potential to life itself, isn't that situation—instead of coming in here saying, "You should turn this over to the States," you should say, "We need a Federal program a la the kidney program that we have in this country, to make sure that that doesn't happen?"

Dr. **Willging.** I am not sure I would agree that we need another Federal program a la the kidney program to deal with those problems in the States. I think the worst of all examples about the kidney program if we look at what we thought that program would cost when first put on the books and what it costs today.

Mr. **Walgren.** One difference between the two programs is the neonatals don't vote.

Dr. **Willging.** It would seem to me, though, even in the entire array of services that States have to make decisions on, to find there are some where they could conceivably slough off, Mr. Congressman—which is not to say they will—we could in effect go through the program and say, "For this one we will not give the States the right to make those decisions; for this one we will."

I think the program originally was supposed to be a State-managed program with the States being accountable for the ultimate decisions. I see no reason to change that. I think the States want to go back to the original program.

Mr. WALGREN. The testimony before this hearing was that the States are not providing neonatal services in particularly the State of Florida, resulting in the deaths of children and the, I am sure, severe life impairments of others.

The reason they are not doing that is strictly financial, period. No monopoly on compassion at the Federal level, at all. Everyone admits that the board of that hospital is as compassionate as anybody else except they don't have the dollars and they don't have the dollars on the State level, either.

Under those circumstances, wouldn't you, knowing that it is cost effective for the taxpayers in the long run, understanding, as you agreed with me would happen, that they would slough over this kind of problem because of the financial pressures on the States, wouldn't you agree that that is exactly the area that we ought to have a Federal program?

Dr. WILLGING. What I am suggesting, Mr. Congressman, is that that is a decision in terms of the State of Florida, that voters in the State of Florida are most capable of making.

Mr. WALGREN. We live in one society. In fact, we have the obligation—it is my responsibility as a Congressman—if I see a need that is unmet in this society, that is appropriately met at the Federal level and that the ethic of the society would expect me to meet, it is my obligation to meet it, whether or not it has traditionally been—whether or not the Federal Government has met it before in the past, or not. You have the same obligation and yet somehow or other it just couldn't—for some reason or another, you have built blinders in some way that prevents you from seeing that obligation.

Dr. WILLGING. How can I respond to that, Mr. Walgren?

Mr. WALGREN. I guess at this point I have to let the record speak for itself.

I want to thank you for your candor in admitting that there are very specific needs that will be sloughed over by the States in this area, unmet, absolutely unmet, and from a cost-effective standpoint we are walking into much greater costs than we would if we cleared out the program.

But apparently the biases within this particular administration are so anti-Federal Government that they are willing to expose that kind of human cost on the public.

I specifically want to say that we have heard this verbal garbage about the Federal Government not having a monopoly on compassion—we are not talking about compassion, here, we are just talking about dollars and cents and the testimony here was that the State government did not have the money. Not that they were callous or anything like that.

The system that we are running, today, limits financial capability of the States in ways that we have an obligation on the Federal level to pick up.

I hope, you know, that the public understands that representatives of the administration are coming forward before the Congress and saying—

> We know there are problems that the State won't pick up and we know it is going to result in retarded children and we know it is going to result in deaths but we think that States have such a—or that the Federal Government is so suspect and the States have such a traditional role that we should not interfere.

Thank you, Mr. Chairman.

Mr. GORE. Thank you, Mr. Walgren.

Are you familiar, Doctor, with the GAO report I referred to earlier dated January 21, 1980, entitled "Better Management and More Resources Needed To Strengthen Federal Effort To Improve Pregnancy Outcome."

Dr. WILLGING. I am not personally familiar with it, Mr. Chairman.

Mr. GORE. The report noted that there are still significant problems, even before the changes in policy that you are recommending, that remain in trying to assure access to neonatal intensive care, particularly for medicaid mothers.

This GAO report noted the refusal of some physicians or hospitals to accept medicaid or low-income patients, or even to refer patients to others.

Does that conclusion surprise you, that they found that?

Dr. WILLGING. No, we have had problems of access in terms of the refusal of providers to deal with medicaid patients but they stem from a variety of reasons of which reimbursement is sometimes the least critical.

Mr. GORE. I would commend the GAO report to you in that regard. It covers reimbursement as quite a significant factor.

The report also recommended to the Secretary of HHS that the Department through the Assistant Secretary for Health undertake a review of—

> What the Federal Government can or should do to help poor persons gain access to in-hospital obstetrical or infant care in cases where hospitals which are not obligated under Federal programs or have already met their obligations to provide some care to persons who cannot pay, refuse to accept such patients. Expanding medicaid coverage and increasing medicaid reimbursement rates should help.

These conclusions by GAO, in addition to the testimony we have heard here today indicate to me that we could save lives by allowing medicaid to expand in that manner.

Do you agree?

Dr. WILLGING. I suspect that I disagree with the proposal which was, in effect: Mandate at this stage additional requirements on the State with respect to medicaid.

Mr. GORE. Provide additional money for medicaid?

Dr. WILLGING. Well, the States in effect make the decision on how much money goes into hospitals.

Mr. GORE. Based in part on how much they received from the Federal Government?

Dr. WILLGING. No, it works the other way, Mr. Chairman. We match what it is the States expend. It doesn't work the other way.

Mr. **Gore**. With a cap in the amount the Federal Government provides, it is limited?

Dr. **Willging**. States could indeed limit reimbursement to hospitals as a result of the cap. That is one of the decisions they might make.

Mr. **Gore**. A soon to be released OTA report entitled "The Cost and Effectiveness of Neonatal Intensive Care" reaches many of these same conclusions. Are you familiar with the OTA report?

Dr. **Willging**. No, I am not, Mr. Chairman.

Mr. **Gore**. I don't think that is out but I think it will be quite soon.

There is a very thorough analysis of the collection of providing neonatal intensive care. I have been reading it all weekend. It identifies inadequate medicaid reimbursement as the key part of the problem.

Reimbursement often is based on, of course, the reasonable cost formula, rather than on charges, and we had an interchange on that earlier.

The disparity between those two is added onto the bills of other patients, thus widening the gap. This creates a vicious circle which will perpetuate unless steps are taken to equalize the system.

As medicaid reimbursement lags further and further behind actual charges for neonatal intensive care, there will be increasing pressure—they are now feeling it—on hospitals, not to accept low-income patients for the high-cost neonatal intensive care treatment.

The problems that have been documented here today in the GAO report and the OTA report, will be exacerbated.

I had a question tied up at the bottom of that, how does the administration plan to respond to the problem, but I take it that the administration does not plan to respond to the problem. The administration plan is to hope that each individual State will respond to the problem. Is that correct?

Dr. **Willging**. Certainly the administration would not propose a move to a simple charge basis in a system of reimbursement no matter how inefficient a hospital may be simply because a hospital cannot cover its costs.

Mr. **Gore**. That wasn't the question.

Does the administration plan to respond only by hoping that each individual State will respond?

Dr. **Willging**. In the medicaid program that is how traditionally the program has been managed and how it would continue to be managed. States would deal with that issue.

Mr. **Gore**. Do you think the cap will have the effect, if it is enacted, of limiting the States response?

Dr. **Willging**. I am sorry, I didn't get that question.

Mr. **Gore**. Do you think the medicaid cap, if enacted, will have the effect of limiting the ability of the States to respond to this problem?

Dr. **Willging**. No. It could very well work the other way. It could increase the ability of the States to deal with that problem.

Mr. **Gore**. By imposing some discipline on them?

Dr. **Willging**. Well, it may well be that the problem is that there are hospitals which aren't capable of providing as efficient a service as are other hospitals and States may be inclined perhaps to deal with those that, given due consideration of access, can in fact meet the efficient parameters of a quality service.

If we have a situation where hospitals' charges are out of sync with hospital costs, it is not the only conclusion one could come to that reimbursement is inadequate. It may well be the hospital's own management structure is inadequate in terms of providing the best quality service at the most efficient price.

I know a little bit about the hospital industry. I was with a hospital for 10 years. It is going to be hard to convince me that any charge incurred by a hospital is reasonable and, therefore, the reimbursement mechanism should pay. It simply doesn't work that way.

Mr. GORE. That is not what I propose, at all, and I would hope that the administration will not go to the other extreme, either, but evidently it is.

I am going to adjourn the hearing in just a moment but let me jut ask you a few more brief questions.

I really have a hard time understanding the kind of cold-eyed statistical approach to this problem in the face of the kind of tragedy that occurred in Florida, which according to the testimony, is not at all uncommon and does occur elsewhere around the country with some frequency.

I mean, doesn't it offend you that infants in need of intensive care would be denied because of financial policy?

Dr. WILLGING. Of course it offends me, Mr. Chairman, but I also have difficulties with policymaking which in effect is based upon emotionally charged issues which may or may not even be reflective of what is going on across the country.

Also, again I hear these issues are not even necessarily medicaid issues. Those five people in Texas, for example, were not even eligible for the program, and we are not sure the decision in Florida had anything to do with medicaid.

I don't know whether I would call it cold-eyed statistics. I think public policy should be based upon some understanding of costs and benefits.

Mr. GORE. I have some trouble with the attitude that we ought to just resign ourselves to the fact that some of these infants are going to be denied intensive care, even though they need it.

I don't think that is acceptable in this country and I don't think most Americans feel that way.

Do you agree with me that a cost-benefit analysis is inappropriate for neonatal intensive care?

Dr. WILLGING. Do I agree with you that it is inappropriate?

Mr. GORE. Yes. That an infant in need of intensive care should be given it, even if it is going to cost a lot of money.

Dr. WILLGING. I am not sure I would presume to speak to the issue of a specific individual. I am not paid to make those kinds of decisions.

I think general policy issues in terms of what is covered, what services are provided, should be dealt with on a reasonably analytic basis.

I think one doesn't, however, have to simply make a choice and this is my difficulty, I think, with the tenor of the hearings thus far. We are only making choices of will somebody get covered or won't they. I think there is a third factor in how we cover people: Can we cover them in a more efficient fashion.

And to assume that the only choice is, you are covered or you are not, or, does the cap kill babies, which I think is a fairly emotionally charged approach to take to these kinds of decisions—I don't accept those as the only options available to us.

Mr. GORE. Well, that is going on in the country today. To say that it ought to stop and we ought to change that, it can be described as an emotional reaction and I suppose to some extent it is but I also think that it is a rational response that most people in this country would agree with.

The OTA study concluded that it is impossible to evaluate neonatal intensive care with cost-effectiveness criteria, but as we have heard earlier, even if you do use such criteria it appears to be quite cost effective.

You did agree with that general premise, did you not, when my colleague from Pennsylvania was questioning?

Dr. WILLGING. Yes.

Mr. GORE. That you do end up saving more money in the long run by providing intensive care, neonatal intensive care?

Dr. WILLGING. It appears to be cost-effective. That is not my area of competence but from what I have read as a layman, yes.

Mr. GORE. And medicaid provides funds for some of the long-term treatment of those impaired, either through mental retardation or cerebral palsy or otherwise, because they have been denied neonatal intensive care; is that correct?

Dr. WILLGING. At State option; they need not provide some of the services.

Mr. GORE. But Federal funds are used for that purpose, right?

Dr. WILLGING. They are available if States make those choices and the individual is categorically eligible.

Mr. GORE. If Federal funds are used for that purpose and you have agreed that you can save that money by spending money for neonatal intensive care to prevent those expenditures, then by denying a Federal role in addressing this problem, it seems to me you are acquiescing in the wasting of Federal money.

Dr. WILLGING. I don't believe I have on any occasion denied a Federal role. What I have said is I would not as a Federal employee deny the States the right to make the appropriate choice. If I were a State legislator, I personally would make that choice. If the State does make that choice there is a Federal role. We would match those funds.

What you are talking about, Mr. Congressman, is mandating a certain service on the States because we think it is more appropriate, or you would think it more appropriate that the States not have an option in that regard.

I think that is a different issue than denying a Federal role, which I do not do.

Mr. GORE. If we can both agree that it is indeed cost-effective to provide neonatal intensive care and by doing so you can avoid other costs down the road, and if we can agree that States are currently not making that choice, why can we not also agree that the

Federal Government ought to play a role in encouraging rational choices in this area?

Dr. WILLGING. I believe you are talking about something more than encouraging rational choices. I believe you are talking about making the choice for the State.

Mr. GORE. Not necessarily. I am talking about a policy that will extend neonatal intensive care to those who are not getting it now. It is cost-effective and it avoids the wasting of Federal money, so why shouldn't we have a policy initiative to reach that result?

Dr. WILLGING. I guess that is where we part company and the administration would part company. I think we are talking about those kinds of basic choices best made at the level of the State itself. There are different views on this issue.

Mr. GORE. Why?

Dr. WILLGING. Why?

Mr. GORE. Why?

Dr. WILLGING. Because I believe that, especially with respect to the medicaid program where up to 50 percent of the funds are provided by the States, and the perspective of the States is better capable of dealing with what they see to be their high priority needs.

In a given State, although we would agree, perhaps, that neonatal care is indeed cost effective, there may be even more critical and more pressing needs that I would prefer to let the State deal with.

Prioritizing health care needs for a State I think is inherently difficult, if not impossible, for the Federal Government to do.

Mr. GORE. Well, I don't know. If we can agree that this would be a rational policy for the entire country, and if we agree that Federal dollars are wasted because the current situation continues, then it seems irrational to hope that 54 different jurisdictions will, on their own, come up with this policy, instead of taking a Federal initiative.

But I understand that one of the cornerstones for the new approach is that the Federal Government should do as little as possible and that States somehow magically have more wisdom than the Federal Government. I guess I just disagree with that.

The administration still supports the 5-percent cap.

Dr. WILLGING. The administration is engaged in negotiations now with the Congress in conference and has indicated a willingness to be flexible; 5 percent is not doing that at this stage.

Mr. GORE. It is my hope that we will be able to pursue this issue on another occasion.

I regret that there was evidently some misunderstanding in some of the questions that I put to you you felt were outside of your legitimate area of responsibility and I don't know how the miscommunication occurred but I appreciate your willingness to come and talk about these issues. We will pursue them on another occasion.

Dr. WILLGING. However it happened I do apologize for any inconvenience caused the committee, Mr. Chairman, by that lack of full understanding.

Mr. GORE. We will pursue it on another occasion.

The hearing is adjourned.

[The following letter was submitted for the record:]

American Academy of Pediatrics

P.O. Box 1034
1801 Hinman Avenue
Evanston, Illinois 60204
Phone (312) 869-4255
Chicago (312) 273-3646

Reply to:
R. Don Blim, M.D.
4400 Broadway
Kansas City, Missouri
64111
(816) 561-8100

President
R. Don Blim, M.D.

Vice-President
Glenn Austin, M.D.

Past President
Bruce D. Graham, M.D.

Executive Director
M. Harry Jennison, M.D.

Executive Board
Richard M. Narkewicz, M.D.
South Burlington, Vermont
Milton Gordon, M.D.
Huntington, New York
Allan B. Coleman, M.D.
Washington, D.C.
Martin H. Smith, M.D.
Gainesville, Georgia
William C. Montgomery, M.D.
Detroit, Michigan
Edmund C. Burke, M.D.
Rochester, Minnesota
William A. Daniel, M.D.
Birmingham, Alabama
James E. Strain, M.D.
Denver, Colorado
Paul F. Wehrle, M.D.
Los Angeles, California

July 21, 1981

John D. Dingell
Chairman, Subcommittee on Oversight
and Investigations
Energy and Commerce Committee
2323 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Dingell:

The American Academy of Pediatrics is pleased to respond to your inquiry regarding the impact of further reductions in Medicaid on the health of infants and children, particularly in view of the recent situation in Florida involving the death of a premature infant. In direct response to your question, this is by no means a problem unique to Florida; it is widespread and in fact a daily crisis in many parts of the country. Problems of this nature are compounded among lower socioeconomic groups (many of whom are Medicaid eligible) who are known to have a higher rate of complications.

During the past decade, the well-being of newborn infants and pregnant women has measurably improved. Perinatal health care is now available in much of this country on a systematic and regional basis. This achievement has been accomplished through conserted and coordinated effort by professionals, philanthropists, and government organizations.

However, serious problems and concerns in perinatal health remain. Uneven application of technology means that not everyone benefits. When one or more of the regional centers are overloaded with patients or short of staff and/or equipment, it is good and common practice to divert a referred baby to another and sometimes distant center. Yet maternal and infant transport services are not always coordinated between areas. Thus, the inevitable fluctuation in demand results in difficulties in locating intensive care units for a patient. Medical and surgical care is capable of assuring a happy and productive life for most newborns, but costs are often very high. They remain totally at the mercy of the family and other advocates for support. Potential reductions in funding for maternal and child health programs will have an immediate effect on the quality and availability of perinatal care, particularly among the poor and disenfranchised. A rural newborn with a surgical emergency, the urban baby with respiratory distress syndrome, the adolescent mother and her child, the premature with an infection, and others are at risk of having their human potential negatively influenced by such reductions.

States must have the flexibility to respond. What this country is facing is a potential systems problem as well as a funding problem. We are delighted that this issue has sparked your interest and would hope you would pursue your investigations in this area. Please know that the Academy stands ready to assist you in this process.

Sincerely yours,

R D Blim M.D.
R. Don Blim, M.D.
President

George A. Little M.D.
George A. Little, M.D.
Chairman, Committee on
Fetus and Newborn

[Whereupon, at 1:39 p.m., the subcommittee was adjourned.]

○